DEPT.- 65

JOB- 21

REEL- 51

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

PP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE: Certificate of Death

2. Form No. if available

3. Type—(cords, paper, etc.) Bound Book

4. Dates

5. Volume accumulated yearly

6. Size of Record: Misc.

7. Number of copies made: One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period

a. In Dept. 12 yrs.

b. In Storage Center Micro. Perm.

c. Total 12 yrs. and Micro. Perm.

10. Equipment and space freed.

11. In your opinion does this record have any historical significance?

YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period

a. In Dept. 12 yrs.

b. In Storage Center Microfilm Permanent

c. Total 12 yrs. and Microfilm Permanent

14. Disposal Method

A. [ ] To be sold as scrap or waste paper

B. [X] To be Burned or shredded

C. [ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85006 ✓ 90 D 85006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret J. Dachse

(a) RESIDENCE NO. 1442 Harford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A. Dachse

6 DATE OF BIRTH (month, day, and year): Jan 22, 1863

7 AGE: Years 61 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Wm Browning

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Hospital Records.

15 Robert P. Harrison, Registrar

MAR 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18, 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1924. to March 18, 1924.

that I last saw h e alive on March 17, 1924.

and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Chr. myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Typical signs & symptoms.

(Signed) B. M. Rhoads, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 3/21 19 24

20 UNDERTAKER: Perkins Funeral — ADDRESS: Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85007

HEALTH DEPARTMENT—CITY OF BALTIMORE

85007

CERTIFICATE OF DEATH.

101-01

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Bayless.

(a) RESIDENCE NO. 1443 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret J

6 DATE OF BIRTH (month, day, and year): April 27 1861

7 AGE — Years: 62 — Months: 11 — Days: 19 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles Sachse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles E. Sachse

(Address): 2334 E. Fairmount

15 Filed MAR 19 1924, 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year): March 18 1924

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1924, to March 18, 1924, that I last saw him alive on March 18, 1924; and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Aschenbrandt, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 3/21 1924

20 UNDERTAKER: Zurkler-Birkler

ADDRESS: 1737 Eager

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85008

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Edwards

(a) RESIDENCE NO. 2015 E. Chase St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie E.

6 DATE OF BIRTH (month, day, and year) Dec 25, 1866

7 AGE — Years: 57 — Months: 2 — Days: 22 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk Marking division P.O.

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: John Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Anna Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Carrie E. Edwards

(Address): 2015 E. Chase st

Filed MAR 19 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1924

17

I HEREBY CERTIFY, That I attended deceased from March 16, 19 24, to March 18, 19 24,

that I last saw him alive on March 18, 19 24,

and that death occurred, on the date stated above, at 6:50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, splenic flexure of colon.

(duration) 2 yrs.? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of March 16, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Henry U. P. Nelson, M. D., M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 3/21 1924

20 UNDERTAKER: Burkhardt & Burkhardt — ADDRESS: 1739 Eager

Burial Permit

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85009

CERTIFICATE OF DEATH.

REGISTERED NO. 48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 N Lanvale ST., 16 WARD)

2-FULL NAME Charles E. Fairbanks

(a) RESIDENCE NO. 1725 N Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 9 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	11	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Van E. Fairbanks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine M. Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Catherine M. Fairbanks

(Address) 1725 N Lanvale St

15 MAR 19 1924 . 19 Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1924, to Mar 19, 1924, that I last saw him alive on Mar. 18, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Edmund C. Todd, M. D.

3/19, 1924 (Address) 735 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore — DATE OF BURIAL MAR 21 1924

20 UNDERTAKER Geo W Little — ADDRESS 2700 EDMONDSON AVE.

Burial Permit Clerk.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 85010

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1725 W Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Geo. Fairbanks

(a) Residence No... 1725 W Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married (or Widowed, or Divorced), (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Kate M. Fairbanks

6-DATE OF BIRTH (month, day and year) 1873

7-AGE, 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Foreman Lumber Yard

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer... B & O R R Co

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Geo Fairbanks

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary Benton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant)... Kate M. Fairbanks

(Address) 1725 W Lanvale St

15- Filed MAR 19 1924, Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) MAR 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct., 1923, to Mar 18, 1924, that I last saw h[illegible] alive on Mar 16, 1924, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis with valvular Heart disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hallie E Tinkman M. D.

(Address) 2002 N Lexington

Mar 18. 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park

DATE OF BURIAL, MAR 20 1924, 19....

20-UNDERTAKER, Geo W Little

ADDRESS 2700 Edmondson Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85011 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-006 85011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 Bourne — ST., 17 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Horsey

(a) RESIDENCE NO. 711 Bourne — ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 18, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edgar Horsey

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Curtis

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md

14 Informant Mary Horsey
(Address) 711 Bourne St

15 MAR 19 1924 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from Mch 18th, 1924, to Mch. 24th, 1924, that I last saw h[illegible] alive on Mch. 24th, 1924, and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth
7 month fetus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bleeding Cause

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur Ellis, M. D.

3/18, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Body sent to Johns Hopkins Laboratory

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 E Monument St., 7 Ward) Registered No. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Pinkney

(a) Residence No. 1502 E Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? 71 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Nurses work

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Lorette P. Brown

(Address) 1143 May St.

15- Filed MAR 19 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 18-24

17- I HEREBY CERTIFY, That I attended deceased from March 11, 1924 to March 17, 1924

that I last saw h[illegible] alive on March 24, 19

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

Infirmity (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? V. C. F.

(Signed) J. Edward Fisher M. D.

3-18, 1924 (Address) 1612 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cremation	March 22 1924
20-UNDERTAKER, John W. Henderson	ADDRESS 1502 E Monument

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-08 ✓ D 85013

1-PLACE OF DEATH

City of BALTIMORE: (No. 303 N. Monroe St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Reynolds

(a) Residence No. 303 N. Monroe St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 23 1922

7-AGE. ..... yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edwin J. Reynolds

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Margaret Setzendanner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14-(Informant) Edwin J. Reynolds

(Address) 303 N. Monroe St.

15-This 19 Mar 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MAR 19 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19 1924

17-I HEREBY CERTIFY, That I attended deceased from March 16 1924 to March 19 1924

that I last saw h— alive on March 19 1924

and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Do

Did an operation precede death? No. Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan M. D.

3/19, 1924 (Address) 21 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cem	March 20 1924
20-UNDERTAKER.	ADDRESS.
Jos Joerdens Son	2173 Pa.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every line must be filled out. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85014

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Block

(a) RESIDENCE NO. 315 S. Eden St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Hyman Block

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Frank Spieseler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinda Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Block (Address) 315 S. Eden St

15 Filed MAR 19 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1924, to Mar. 19, 1924, that I last saw h[illegible] alive on Mar. 19, 1924, and that death occurred, on the date stated above, at 8[20] A-m.

The CAUSE OF DEATH* was as follows:

Shock following Operation for complete Intestinal obstruction

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar. 19, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. Exam

(Signed) G. F. Goff M. D.

3/19, 1924 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Sholem Cem	Mar 20, 1924
20 UNDERTAKER Wm. Levinson Bro	ADDRESS 1127 E Balto

Burial Permit

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85915

CERTIFICATE OF DEATH.

90 D 85915

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 S. Sticker ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennaja J. Shreiner

(a) RESIDENCE NO. 116 S. Sticker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ~ mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amy Hadley

6 DATE OF BIRTH (month, day, and year) February 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O Railroad

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Shreiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Spangler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Annie Crancroft

(Address) 110 S Sticker St

15 Filed MAR 19 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1924

17

I HEREBY CERTIFY, That I attended deceased from January 22, 1924, to March 18, 1924, that I last saw h alive on March 17 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Evans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	March 20 1924
20 UNDERTAKER E. L. Stiffler	ADDRESS 125 E North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35016

CERTIFICATE OF DEATH.

D 35016

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Jackson ST. 24 WARD)

2-FULL NAME Mary A Clark.

(a) RESIDENCE. NO. 1414 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jasper W. Clark.

6 DATE OF BIRTH (month, day, and year) Jan 22 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mid-Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Getz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Clark
(Address) 1414 Jackson St.

15 Filed MAR 19 1924 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 9 1924, to March 19, 1924, that I last saw h e alive on March 19, 1924, and that death occurred, on the date stated above, at 8a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chron Bright Disease

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S/ Roberta M. D.

3/19 1924 (Address) 1279 Williams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL March 22 1924

20 UNDERTAKER Margaret L. Flynn

ADDRESS 1422 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85017

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 85017

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 8 E. Randall St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Margaret E. Gallagher

(a) Residence No. 8 E. Randall St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick J. Gallagher

6-DATE OF BIRTH (month, day and year) May 22, 867

7-AGE, 56 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or.....mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER Geo. R. Casito

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Mary E. Lovett

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Ireland

14- (Informant) George Gallagher

(Address) 8 E. Randall St.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 22 24

17- I HEREBY CERTIFY, That I attended deceased from Mch 22, 1923, to Mch 17, 1924, that I last saw her alive on Mch 17, 1924, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(Duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted, if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? U. A. Analy.

(Signed) George L. Duane, M. D.

3/18/24 19.. (Address) 721 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral Cem.	March 21, 1924
20-UNDERTAKER, Margaret A. Flynn	ADDRESS 1422 Light St.

MAR 19 1924 Burial Permit Clerk.

MARGIN RESERVED FOR BINDER.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85018

CERTIFICATE OF DEATH.

D 85018

1-PLACE OF DEATH

CITY OF BALTIMORE. No. Ft Sq Hospital 9 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis H. Hoosord

(a) RESIDENCE No. 704-6th St. Washington D C, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) Auto
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lutherania

PARENTS

10 NAME OF FATHER Solomon Aronson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lutherania

12 MAIDEN NAME OF MOTHER Freda Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lutherania

14 Informant J. Lewis
(Address) 1439 E. Balto St.

15 Filed Robert P. Harrison, Registrar
MAR 19 1924 Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto Accident.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. ds.

(Signed) Geo Clinton Wades, M. D.
(Coroner.)

3/19/24, 192 (Address) 143 N Gay

*State (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington, D. C.	March 20 1924

20 UNDERTAKER Jas T Lewis, 1439 E Balto
ADDRESS

M. B.—WRITE WITH UNFADING INK—THIS CERTIFICATE
mation should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T [illegible]

D 85019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X166 D 85019

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 N. Broadway ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth M. Lance M.D.

(a) RESIDENCE No. 44 Reynolds ST. Kingston PA. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) Nov. 21/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Plymouth Pa.
(State or country)

PARENTS

10 NAME OF FATHER Oscar M. Lance

11 BIRTHPLACE OF FATHER (city or town) Minersville
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Ellen Hancock

13 BIRTHPLACE OF MOTHER (city or town) Kingston
(State or country) Pa.

14 Informant John H. Lance (Bro.)
(Address) 44 Reynolds St. Kingston,

15 Filed MAR 20 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probable Cyanide Poisoning
Probable Suicide
(Autopsy at Hopkins Hospital)
(Chemical Analysis not Completed.
(duration) yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)
(duration) 2 yrs. mos. ds.

(Signed) J. S. H. Culler M. D.
(Coroner.)
Mar 19/24 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kingston Pa

DATE OF BURIAL March 20 1924

20 UNDERTAKER Richard F. Cauley

ADDRESS 1108 Pine St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

CERTIFICATE OF DEATH.

D 85020

D 85020 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S. Robinson St. ST., 1 WARD)

2-FULL NAME Leo Stofer

(a) RESIDENCE NO. 606 S. Robinson St ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Stofer.

6 DATE OF BIRTH (month, day, and year) Jan. 31-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	64	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Coppersmiths.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Stofer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Bosinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Marie Stofer.
(Address) 606 S. Robinson St.

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1924

17 I HEREBY CERTIFY, That I attended deceased from 12 June, 1923, to 16 Mar, 1924, that I last saw him alive on 15 Mar, 1924, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Rectum and Bladder

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) D. Timothus, M. D.

, 19 (Address) 301 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	March 20 1924
20 UNDERTAKER Lilly & Zeiler.	ADDRESS 403 S. Wolfe St.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 85021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 85021

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard G. Reif

(a) Residence No. 3518 Gough st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, George Leonard Reif

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Kate Mittlander

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from December 31 1923 to March 19 1924

that I last saw him alive on March 19 1924

and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray and sputum

(Signed) L. A. Lilly M. D

3-19-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (I) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gunp. Cem.	March 21 1924
20-UNDERTAKER, Lilly & Zeile	ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16948 D 85022

38 D 85022

REGISTERED NO. 7

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME George A. Hatchett

(a) RESIDENCE NO. 12 Houghton ST ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X		5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Katie Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 26 1924, 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1924.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1924, to Mar. 17, 1924, that I last saw him alive on March 17, 1924, and that death occurred, on the date stated above, at 3 35 A. m.

The CAUSE OF DEATH* was as follows:

Congenital syphilis

(duration) Life yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Wassermann

(Signed) A. A. Weed, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 26 March 1924

20 UNDERTAKER R. L. Parker

ADDRESS 902 Lexington

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85023

CERTIFICATE OF DEATH.

11 D 85023

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Darley Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H. Burns

(a) RESIDENCE NO. 1712 Darley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy A.Burns

6 DATE OF BIRTH (month, day, and year) April 25 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	73	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work retired watchman
(b) General nature of industry, business, or establishment in which employed (or employer) 062
(c) Name of employer

9 BIRTHPLACE (city or town) Elkridge
(State or country) Md.

PARENTS

10 NAME OF FATHER William Burns

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A.Wells

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Claude T.Burns
(Address) 1712 Darley Ave.

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Indigestion (Pork & sauerkraut) (duration) 2 yrs. mos. ds.

(Signed) J S T Wallen, M. D.
(Coroner.)

Mar 18/24 192 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Md	Mar 20 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 85024

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 85024

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkin Hospital WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris Siemer

(a) RESIDENCE NO. 939 S Paca St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25/923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles F Siemer

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Gertrude Bensing

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Mrs Chas F Siemer
(Address) 939 S Paca

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J H Waller, M. D. (Coroner.)

Mar 18/1924 (Address) 508 . North Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 20 1924

20 UNDERTAKER John F Denny — ADDRESS 710 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—RESERVED FOR BINDING

Cor.—1-12-25—M&T—100 Bks.

Wawrzyniak

D 85025

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 85025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaus C. Wawrzyniak

(a) RESIDENCE NO. 808 S. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6-1885.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	0	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shop Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Wawrzyniak

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Maggie. —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Bronislaus Wawrzyniak, Bro.
(Address) 808 S. Potomac St.

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Multiple Fracture accident

(duration) Shock yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) G. Lattner Blades, M. D.

(Coroner) Mar 21, 1924 (Address) 1436 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL Mar 21 1924

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85026

CERTIFICATE OF DEATH.

44 B 85026

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Enroute to Hebrew Hospital ST., 6 WARD)

2-FULL NAME Morris Greenberg

(a) RESIDENCE NO. 2100 E. Baltimore St., Hebrew Incurable Home ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Single~~ Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mirian Greenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Delia Greenberg

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mary -----

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant .....
(Address) 1434 E Balto St

15 Filed MAR 20 1924 ROBERT R. KRAMER (Registrar)
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kraus, (Coroner.) M. D.

Mar 20/24 (Address) 508 3. NOrth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rush Rd	3/20/24
20 UNDERTAKER	ADDRESS
Jack Lewis	1434 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85027 — 1924 61 — 18 85027 63

REGISTERED NO. 12 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 N Carey ST. 16 WARD)

2-FULL NAME Rebecca Gray

(a) RESIDENCE NO. 1145 N Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Gray

6 DATE OF BIRTH (month, day, and year) Mch 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary Co Md

PARENTS

10 NAME OF FATHER Henry Woodland

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Sent Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Mrs Johnson Price

(Address) 1145 N Carey

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1924, to March 18, 1924, that I last saw her alive on March 18, 1924, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

2 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) H. S. McGaud, M. D.

3/19 1924 (Address) 2005 D Hillen Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Mch 21 1924

20 UNDERTAKER Emmert & Crofford — ADDRESS 364 W Con

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85028 HEALTH DEPARTMENT—CITY OF BALTIMORE 85028

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH

City of BALTIMORE: (No.) 560 Greenwillow St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Holland

(a) Residence No. 560 Greenwillow St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Holland

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 34 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic Servt

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Samuel Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hettie Gassaway

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) John H. Gassaway

(Address)

15-

Filed ..... 19.. ROBERT R. KRAUTER Registrar.

MAR 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-16-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 13 1924, to Mar. 17 1924

that I last saw h.E.W. alive on Mar. 17 1924

and that death occurred, on the date stated above, at 3:35 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 1 mos. ? ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jno. H. Fortmann M. D.

19 (Address) 1119 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt Auburn Cem	3-20 1924
20-UNDERTAKER,	ADDRESS
Dan'l Easton	64 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOTICE: REGISTERED FOR BINDING.

Spec--12-23-21--E.B.R.S.--400 Bks.

(August. Lemm)

D 85029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85029

1-PLACE OF DEATH

City of BALTIMORE: (No. At Aqus (Hospital) St. Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Lemm

(a) Residence No. 3336 Frederick Ave St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Lamm

6-DATE OF BIRTH (month, day and year) Nov 23, 1871

7-AGE. 52 yrs. 3 mos. 24 ds. If LESS than 1 day, hrs. or mlo.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Florist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Rimrod

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Katie Lemm

(Address) 3336 Frederick Ave

15- Filed ..... 19 ROBERT R. KRAUTER Registrar.

MAR 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924, to Mar 18 1924, that I last saw h. alive on Mar 18 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH was as follows:

Ulcer Tuberculous; Gall-stones, Abscess of Tibia of left leg.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia and Cardiac failure

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 14 24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) 3336 Frederick Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL. March 21 1924

20-UNDERTAKER C. W. Dill. — ADDRESS 3109 Frederick Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85030

CERTIFICATE OF DEATH.

1924 D 85030

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 76 WARD)

2-FULL NAME Milton A. Willner

(a) RESIDENCE NO. 3907 Fernwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct 10/98

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler Worker 086
(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil Co
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Andrew Willner

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Maggie Kimpel

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Maggie Willner
(Address) 3907 Fernwood Ave

Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- fell from tank.
(Frac. Skull, wrists & jaw.)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Oates, M. D.
(Coroner.)

Mar 20 /24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL 3/22 1924

20 UNDERTAKER Zirkler & Zirkler — ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85031 CERTIFICATE OF DEATH. 101-001 D 85031

1-PLACE OF DEATH

City of BALTIMORE: (No. 244 N Bruce St., 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Overton

(Residence in Baltimore: No. 244 N Bruce St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. May (Month) 1 (Day) 1913 (Year)

7-AGE. 10 yrs. 10 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Wm Overton

11-BIRTHPLACE OF FATHER, (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER, Mary Carroll

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Overton

(Address) 244 N Bruce St

15- MAR 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 17 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Kenton M. D. (Coroner.)

3/19 1924 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, HOPKINS HOSPITAL DATE OF BURIAL, MAR 20 1924

UNDERTAKER, Commissioner of Health, ADDRESS

Cor.—1-12-23—M&T—100 Bks.

D 85032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hutchinson Mansion Beyond 5 ft. 2300 N. Fulton ST., 43 WARD)

REGISTERED NO. 85032

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about Mar 1 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			one	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER a

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Asst Supt Bowersox

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) about Mar 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Morrison, M. D.
(Coroner.)

Mar 19, 1924 (Address) 1122 Rlandina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	MAR 20 1924
20 UNDERTAKER	ADDRESS
Commissioner of Health,	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 85033

D 85033

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hinton

(a) Residence No. 615 N. Paca Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colred	Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen Hinton

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
60 yrs. ... mos. ... ds.	... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labrer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, David Hinton

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Julia —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant):

(Address):

15- MAR 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-17-24

17- I HEREBY CERTIFY, That I attended deceased from March 8 1924 to March 17, 1924

that I last saw him alive on March 17, 1924

and that death occurred, on the date stated above, at 10-45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Cardium

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Fiulton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
20-UNDERTAKER.	ADDRESS

STATE OF MARYLAND, Commissioner of Health, MAR 20 1924

1255

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85034

CERTIFICATE OF DEATH.

100 D 85034

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 McCulloh ST., 14 WARD)

2-FULL NAME Willie Jennings.

(a) RESIDENCE NO. 1818 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Minnis.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elva Carroll

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Elva Minnis.
(Address) 1818 McCulloh. St.

15 MAR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 11 1923 to Mar. 17 1924

that I last saw h alive on Mar. 17 1924

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Asthenia.

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms.

(Signed) W. J. Carr, Jr. M. D.

(Address) 515 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL MT. AuBurn Cem.

DATE OF BURIAL 3/20 1924

UNDERTAKER Saurl T. Hemsley.

ADDRESS 578 Biddle

Spec.—1-16-21—M&T—1500 Blks.

D 85035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85035

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH University Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Rosalie ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Moulton

(a) RESIDENCE NO. 1507 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm G. Moulton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Isabella Eccles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: University Hosp

(Address)

15 MAR 20 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/24 19

17 I HEREBY CERTIFY, That I attended deceased from 3/17/24, 19 to 3/18/24, 19,

that I last saw her alive on 3/18/24, 19,

and that death occurred, on the date stated above, at 11 20 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test

(Signed) John M. Edmonds, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: Mar 21 1924

20 UNDERTAKER: Wm Tickner & Son

ADDRESS: North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85036

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85036

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2956 Presstman St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Emma J. Belbin

(a) Residence No. 2956 Presstman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 21 1856

7-AGE, 67 yrs. 8 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Wm Belbin

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), England

12-MAIDEN NAME OF MOTHER, Martha Davis

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), England

14-

(Informant) Mrs. V. O. Carrickson

(Address) 2956 Presstman St

MAR 20 1924 ROBERT R. KRAUTER, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) MAR 19 1924

17- I HEREBY CERTIFY That I attended deceased from Jan 10, 1924, to Mar 18, 1924,

that I last saw h~~e~~r alive on Mar 18, 1924,

and that death occurred, on the date stated above, at 5 ~~A~~ m.

The CAUSE OF DEATH* was as follows:

General Abdominal Carcinoma

~~Heart failure~~ (Duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY Malignant (Secondary)

Cachexia (Duration) ✓ yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? yes Date of? Jan 19-1924.

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) John A. Treland M. D.

MAR 19 1924 (Address) 219 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL, Mt O Cem

DATE OF BURIAL, MAR 21 1924, 19...

20-UNDERTAKER, Geo W Little

ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85037

CERTIFICATE OF DEATH.

100-001

D 85037

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2640 Huntington Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Louise C Hinterniseh

(a) Residence No. 116 S 3rd St

(Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Ernest Hinterniseh

6-DATE OF BIRTH (month, day and year) Apl 22

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Lula Barton

(Address) 2640 Huntington

15- MAR 20 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 18 1924

17- I HEREBY CERTIFY, That I attended deceased from March 3, 19 24, to March 18, 19 24,

that I last saw h. alive on March 18, 19 24,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) [illegible], M. D.

Mar 19, 19 24 (Address) 3 E 3 Chestnut Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: March 20 1924

20-UNDERTAKER, — ADDRESS

C. HENOWETH & SON

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85038 — No 85038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1035 E. Chase St., 18 Ward) — Registered No. 90

2-FULL NAME. Edward L. Ballach

(a) Residence No. 1035 E. Chase St., Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	4-Single, Married, Widowed, or Divorced. (Write the word.)
M	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) aug 5 1846

7-AGE. 77 yrs. mos. ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Plain Smith

(b) General nature of Industry, business, or establishment in which employed (or employer). 006

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Carl Ballach

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Louis C Ballach

(Address) 1035 E Chase

MAR 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/19/24

17- I HEREBY CERTIFY, That I attended deceased from 1/19/24, 19.., to 3/19/24, 19.., that I last saw h.. alive on 3/16/24, 19.., and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Art. Sclerosis

Chr. Myocarditis

Contributory

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Brandt Fay, M. D.

3/20, 19 24 (Address) 1210 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	Mar 22 1924
20-UNDERTAKER.	**ADDRESS**
Robt J Turner	1412 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85039

CERTIFICATE OF DEATH.

90 D 85039

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Scott ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura E. Haslam

(a) RESIDENCE NO. 1114 Scott ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jefferson H. Haslam

6 DATE OF BIRTH (month, day, and year) July 12 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	68	8.	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Riley S. Williamson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Laura Higbee
(Address) 629 Washington Blvd.

15 Filed MAR 20 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1924 to Mar 19 1924

that I last saw h... alive on Mar 19 1924

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Dropsies

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. F. H. Campbell M. D.

(Address) 1646 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eastern Cemetery — DATE OF BURIAL: March 21 1924

20 UNDERTAKER: Mr & Mrs John H. Teufel & Son — ADDRESS: 801 N. Fayette St.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 85040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1574-001 ✓

REGISTERED NO. D 85040

1-PLACE OF DEATH 1127 E. Comm'

CITY OF BALTIMORE: (No.) Griffith & Linden ave — ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard B. Daugherty

(a) RESIDENCE. NO. 4007 Brdr ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith K. Daugherty

6 DATE OF BIRTH (month, day, and year) Mar 15 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Daugherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Bassett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edith K. Daugherty
(Address) 4007 Brdr ave

15 Filed MAR 20 1924 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1924. 19 . to March 18. 1924 that I last saw h[illegible] alive on March 18. 1924 and that death occurred, on the date stated above, at 5-P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

4 months
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. K. Jones, M. D.

Mar. 20 1924 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	March 21 1924
20 UNDERTAKER	ADDRESS
W M Routson	2238 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85041

CERTIFICATE OF DEATH.

23 B 85041

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Bowling

(a) RESIDENCE NO. 628 Belle Air WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Alex Bowling

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 50 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md.

PARENTS

10 NAME OF FATHER: Alex Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliz Lawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records

(Address)

15 Filed MAR 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/18/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/17/1924, 19..... to 3/19/1924.

that I last saw h alive on 3/19/1924, 19

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

(Probably) Epidemic Cerebro Spinitis

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: , 21 1924

20 UNDERTAKER: George A Farley — ADDRESS: Fulton ave Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85042 — 161-24 — 85042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 S. Vincent ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Hessler

(a) RESIDENCE NO. 224 S. Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Ferdinand Hessler

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Ferdinand Hessler
(Address) 224 S. Vincent St

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1924, to March 19th, 1924, that I last saw him alive on March 18th, 1924 and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Immaturity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prematurity 36 WKS.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Louis H. Douglass, M. D.

3-17 1924 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/20/24
20 UNDERTAKER	ADDRESS
Joyce & Farley	Fulton & Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85043

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 85043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Albion Hotel

CITY OF BALTIMORE: (No. 900 Cathedral ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Ellicott

(a) RESIDENCE No. 900 Cathedral St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew E. Ellicott

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Ro. Tabbin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. James Casey

(Address) Baltimore Md.

15 Filed MAR 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1920 to March 20 1924, that I last saw her alive on March 20 1924, and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) Geo. E. Brown, M. D.

, 19 (Address) 170 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	March 22nd 24
20 UNDERTAKER	ADDRESS
Henry Jenkins & Co	Oakland

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85044

CERTIFICATE OF DEATH.

101-01 85044

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Stricker ST., 16 WARD)

2-FULL NAME Matthias Bruyford

(a) RESIDENCE NO. 1023 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 28-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	23	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) A.A. Co. Md

PARENTS

10 NAME OF FATHER Matthias Bruyford

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A. Co. Md

12 MAIDEN NAME OF MOTHER Sophia Tucco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A. Co Md.

14 Informant Mother-in-law Bruyford

(Address) 1023 N. Stricker St

15 Filed MAR 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/ 19 24

17

I HEREBY CERTIFY, That I attended deceased from March 1st 1924 to March 19th 1924, that I last saw him alive on March 18th 1924, and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Heart Trouble

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Sputum ✓

(Signed) H. Blacock, M. D.

, 19 (Address) 612 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION or REMOVAL Md Lahor A. 9. 60

DATE OF BURIAL 3-21 1924

20 UNDERTAKER George T. A. Gibson

ADDRESS 1735 Druid Hill Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85045

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85045

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 Rutland ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Macauley

(a) Residence No. 1603 Rutland ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret Macauley

6-DATE OF BIRTH (month, day and year) Feb 15 1850

7-AGE, 74 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore City Md

PARENTS.

10-NAME OF FATHER, Eliza Macauley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Co Md

12-MAIDEN NAME OF MOTHER, dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-

(Informant) Mrs Jessie Macauley

(Address) 1603 N. Rutland Ave

15-

Mar 20 1924, Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 18/24

17- I HEREBY CERTIFY, That I attended deceased from Mar 4th, 19 24, to Mar 18th, 19 24

that I last saw h[illegible] alive on Mar 14, 19 24

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY Arteriosclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W Anderson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Parkview, DATE OF BURIAL, 3/21/24

20-UNDERTAKER, J. A. Moran, ADDRESS 300 E Baltimore St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See Instructions on back of certificates.

Spec--12-23-21--E.B.R.S.--400 Bks.

D 85046

HEALTH DEPARTMENT—CITY OF BALTIMORE

146 D 85046

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 108 N. Lakewood ave St., 6 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mildred L. Grimes

(a) Residence No. 108 N. Lakewood ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): June 18, 1904

7-AGE: 19 yrs. 8 mos. ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Operator
(b) General nature of industry, business, or establishment in which employed (or employer): Telephone Co
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Howard County

PARENTS.

10-NAME OF FATHER: Geo. E. Grimes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Howard County

12-MAIDEN NAME OF MOTHER: Stella Sauerwein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Howard Co.

14-Informant: Geo. E. Grimes
(Address) 108 N. Lakewood ave

15-Filed MAR 26 1924 Robert F. Harris Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 18/24

17-I HEREBY CERTIFY, That I attended deceased from Mar 9 1924 to Mar 18 1924 that I last saw her alive on Mar 18 1924 and that death occurred, on the date stated above, at 7:45 P.M. The CAUSE OF DEATH* was as follows:

(1) Puerperal Peritonitis

(Duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Lanley M. D

Mar 19, 1924 (Address) 1301 N Patterson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lakewood Cemetery	March 24 1924
20-UNDERTAKER,	**ADDRESS**
Geo. J. Butler	1735 Harford Ave.

B—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85047

CERTIFICATE OF DEATH.

90 D 85047

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Fulton Buckley St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Little Sister of Poor

(a) Residence No. Preston Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 82

7-AGE. 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Cornelius Buckley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ire.

12-MAIDEN NAME OF MOTHER. Murray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ire.

14- (Informant) Sister Superior

(Address) Preston Valley

15- Filed ..... 19.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 1924

17- I HEREBY CERTIFY, That I attended deceased from No record, 19.., to ....., 19....., that I last saw h. alive on March 16, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Albanese, M. D.

(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Johns Westminster Md. — DATE OF BURIAL, 3/22, 1924

20-UNDERTAKER. H. Bankard & Son — ADDRESS Westminster

APR 2 1924

Burial Permit Clerk.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35048

CERTIFICATE OF DEATH.

74-00 D 85048

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Murray

(a) RESIDENCE NO. 1104 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~xxx~~ yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a If married, widowed or divorced HUSBAND of ~~the late~~ (or) ~~WIFE~~ of Mary Murray

6 DATE OF BIRTH (month, day, and year) ~~Nov 15~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Dec~~	60	Not stated		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer Odd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Nicholas Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Ryan

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Mary Downey
(Address) 1104 Greenmount Ave

Filed MAR 20 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contract Pneumonia

Epidemic Influenza (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac (duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

March, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa. DATE OF BURIAL March 21 192 4

20 UNDERTAKER Henry Hosch Son ADDRESS 1301 E Eager St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 85049

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001 D 85049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Landon

(a) RESIDENCE No. 2116 W. Vine St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Nov. 4/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	1	4	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Landon

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hilda Dinstbier

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant John T. Landon
(Address) 2116 W. Vine St

15 Filed MAR 20 1924, 192

Robert F. Harrison
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Otitis Media
(Meningitis-Cerebral Abcess)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) J. S. Owen, M. D.
(Coroner.)

Mar 20/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 22 192 4
20 UNDERTAKER	ADDRESS
F. B. Wagner	2236 Fleet Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85050 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85050

57

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1546 Hanover St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hoffman

(a) Residence No. 1546 Hanover St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Halbert Hoffman

6-DATE OF BIRTH (month, day and year) June 15. 1852

7-AGE. 71 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer.....

BIRTHPLACE (city or town) (State or Country). Balto. Co., Md

PARENTS.

10-NAME OF FATHER. John Schwartz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Europe

14- (Informant) Mrs. Jos. Smith (Address) 1546 Hanover St.

15- MAR 20 1924 Robert P. Marriage Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21. 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 15 1924 to Mar 20 1924 that I last saw h. alive on Mar 20 1924 and that death occurred, on the date stated above, at 6-30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. S. Campbell M. D.

Mar 20, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. March 24 1924

20-UNDERTAKER Margaret L. Flynn ADDRESS 1622 Light St.

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85051

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-60 D 85051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Mount ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Eva Ayer

(a) RESIDENCE No. 15 W Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Jan. 25 1872

7 AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work Domestic servant, 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs. Sidney Walters Cal. 2-6610

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Sidney Walters, (Address)

15 Filed MAR 20 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5 1924 to Mar. 18, 1924 that I last saw h[illegible] alive on Mar. 17, 1924 and that death occurred, on the date stated above, at 4:20 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 10 yrs. (approximately) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. of Bl. Picture Autopsy

(Signed) A. A. [illegible] M. D.

, 19 (Address) 1112 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL 3/21/1924

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette ADDRESS

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35052

CERTIFICATE OF DEATH.

D 35052

1-PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1808 Jackson ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME E. Elizabeth Dowling

(a) RESIDENCE. NO. 1808 Jackson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Dowling

6 DATE OF BIRTH (month, day, and year) Aug 16. 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER A. Galloway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rena Smithson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr. Dowling (Address) 1808 Jackson St.

15 Filed MAR 20 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 19 24, to Mar. 19, 19 24, that I last saw h 69 alive on Mar. 18, 19 24, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) W. T. Peabody, M. D.

3/20. 19 24 (Address) 638 Fork Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	3/21/ 24
20 UNDERTAKER	ADDRESS
E. D. Fanning, Inc.	1460 Battery Ave.

MARK IN RED INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. W. S. Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85053 ✓ B 85053

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Annie Goss 1824 Jackson St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1824 Jackson

(a) Residence No. 1824 Jackson St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W.

5-Single, Married, Widow, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam Goss

6-DATE OF BIRTH (month, day and year): unknown

7-AGE. Last 82 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): S. Carolina

PARENTS.

10-NAME OF FATHER: James Henderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): S.C.

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-

(Informant): John Goss

(Address): 1824 Jackson St.

15-

Filed MAR 20 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3/20/24

17- I HEREBY CERTIFY, That I attended deceased from Mar 17, 1924 to Mar 19, 1924, that I last saw h— alive on Mar 19, 1924, and that death occurred, on the date stated above, at 12 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Smith M. D.

Mar 20, 1924 (Address) 109 W. Lee St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cemetery	3/22/1924
20-UNDERTAKER,	ADDRESS
E. J. Fanning & Son	1466 Battery Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85054

CERTIFICATE OF DEATH.

179 D 85054

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Woodyear ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bowie

(a) RESIDENCE NO. 1010 Woodyear ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Calvert Co Maryland

PARENTS

10 NAME OF FATHER Tilyon Bowie

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ellen Chew

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Maryland

14 Informant Mrs Lorane West (Address) 1011 Woodyear St.

15 Filed MAR 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to March 18, 1924, that I last saw him alive on March 18, 1924, and that death occurred, on the date stated above, at 4.40P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank A Saunders, M. D.

3-19-1924 (Address) 1117 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orings Station Md	Mch 20, 24
20 UNDERTAKER	ADDRESS
Sam'l. H. Chase & Son	1400 Maker

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85055 100-001 D 85055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1225 Hanover St, St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Balch

(a) Residence No. 1225 Hanover St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Balch

6-DATE OF BIRTH (month, day and year) Oct. 29 1833

7-AGE. 40 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Stone mason
(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country).....

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... Unknown
(State or Country).....

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country).....

14- (Informant) Mrs Mary Stall
(Address) 1225 Hanover

15- Filed MAR 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 18-24

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 1924 to March 18 1924
that I last saw h[illegible] alive on March 1 1924
and that death occurred, on the date stated above, at 3:50 a. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 25 ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of.....
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Hugo to Stevens M. D
3/18. 1924 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
National	3-21, 19.24
20-UNDERTAKER. Wm Cook	ADDRESS 502 E Mare

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-802 85056

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 428 E Fort Ave (St.) 24 (WARD)

2-FULL NAME Mary L Diriny

(a) RESIDENCE. NO. 428 E Fort Ave. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) WIFE of James F Diriny.

6 DATE OF BIRTH (month, day, and year) Sept 6 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Millenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John E. Diriny (Address) 428 E Fort Ave

15 Filed MAR 21 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Mar 19, 1924 that I last saw h[illegible] alive on Mar 19, 1924 and that death occurred, on the date stated above, at 12.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney H. Shuff, M. D.

(Address) 428 E Fort Ave 3/20 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 22 1924
20 UNDERTAKER	ADDRESS
Wm Cook Sons	E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85057

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 5711 Oak Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary Jane Waite

(a) Residence No.. 5711 Oak Rd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Noah W. Waite

6-DATE OF BIRTH (month, day and year): June 8/1840

7-AGE: 84 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Dayton Ohio

PARENTS.

10-NAME OF FATHER: Joseph Howard

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Dayton Ohio

12-MAIDEN NAME OF MOTHER: Rena Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Dayton Ohio

14-
(Informant): Mrs. Agatha Egan
(Address): 5711 Oak Rd

15-
MAR 21 1924
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 19/24

17- I HEREBY CERTIFY, That I attended deceased from Feby 19, 1924, to Mch 19, 1924, that I last saw h.e alive on Mch 19, 1924, and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Embolism (Arterial)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

3 20, 1924 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, March 22 1924
UNDERTAKER. Wachsmuth	ADDRESS Wilkens & Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.—400 Blks.

D 85058

HEALTH DEPARTMENT—CITY OF BALTIMORE

34 85058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Richard Allen

(a) Residence No. 409 Hamburg st. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1886

7-AGE. 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer). Unknown

(c) Name of employer. Unknown

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Allen

11-BIRTHPLACE OF FATHER (city or town). (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Mary Rawlin

13-BIRTHPLACE OF MOTHER (city or town). (State or Country) Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed MAR 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 6 19 24 to March 18 19 24

that I last saw him alive on March 18 19 24

and that death occurred, on the date stated above, at 12.30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 9 ds

CONTRIBUTORY (Secondary) Pott's disease

(Duration) 1 yrs. 7 mos. ds

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. A. Kalb M. D

3-18-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Auburn	Mch 21 1924
20-UNDERTAKER,	ADDRESS 142
John H. Joachim	Ushers St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85059

100-09

D 85059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2215 Druid Hill Ave St., 14 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Nickens

(a) RESIDENCE NO. 2215 Druid Hill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1859

7 AGE: 65 Years | Months | Days

11 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Edgy Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Frances Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Williamette Nickens
(Address) 2215 Druid Hill

15 Filed MAR 21 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY, That I attended deceased from March 19 1924 to March 19 1924 that I last saw her alive on March 19 1924 and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Coleman M. D.

March 19 1924 (Address) 1138 E Mc Culloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: March 22, 1924

20 UNDERTAKER: John H. Toadvine — ADDRESS 1413 Linden Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85060

CERTIFICATE OF DEATH.

38

D 35060

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Sharp ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Edw. Bias

(a) RESIDENCE. No. 911 Sharp ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Essie Bias

6 DATE OF BIRTH (month, day, and year) Apr. 12 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Kpr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. Bias

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Brown

13 BIRTHPLACE OF MOTHER (city or town) Cambridge
(State or country) Md.

14 Informant Essie Bias
(Address) 911 Sharp

15 Filed MAR 21 1924, 19.... ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18th 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1924, to Mar 18, 1924, that I last saw him alive on Mar 18, 1924, and that death occurred, on the date stated above, at 8.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart
Aortic Insufficiency (duration) 14 yrs. mos. ds.
Luetic

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Conner, M. D.

3/19, 1924 (Address) 1402 Westwell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 22 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1402 Westwell St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85061

CERTIFICATE OF DEATH.

100-91 85061

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 E. Lee ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Johnson

(a) RESIDENCE NO. 21 E. Lee St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 19/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	✓	1 —		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Connell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Information Agnes Johnson (Address) 21 E. Lee St.

15 Filed MAR 21 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 19, 1924, to Mar 19, 1924, that I last saw her alive on Mar 19, 1924, and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) W. D. Smith M. D.

(Address) 109 N. Lee St. Mar 19, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mch 21 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 17 Mulberry St

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK

N. 3—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—P.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85062

CERTIFICATE OF DEATH.

3/4 D 85062

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal tuberculosis Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kutz

(a) Residence No. 305 S. Bond st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Separated

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6-DATE OF BIRTH (month, day and year) 1883

7-AGE. 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Frank Kutz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Austria

12-MAIDEN NAME OF MOTHER. Maggie Brnacikski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Austria

11- (Informant) Hospital Records

(Address) M.T.H.

16- MAR 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

17-DATE OF DEATH (month, day and year) March 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from October 22 19 23 to March 19 19 24

that I last saw him alive on March 19 19 24

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray and sputum

3-20-24 (Signed) L.A. Lally, M. D

(Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL. March 22 1924

20-UNDERTAKER: F.W. Ozozenski

ADDRESS 1930 Eastern Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85063

CERTIFICATE OF DEATH.

90 D 85063

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 115 S-5th St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad H. Scholl

(a) RESIDENCE NO. 115 S-15th St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne Ramsel

6 DATE OF BIRTH (month, day, and year) July 6 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Henry Scholl

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Chas Scholl
(Address) 2765 3rd St

15 Filed MAR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Broken Compensations

(duration) 1 yrs. 2 mos. 4 ds.

(Signed) Jos Ellerbrock Yoder, M. D.

3/20/24, 192 (Address) 143 N Bway (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Conn	Mar 22 192 4
20 UNDERTAKER John Ellerich	ADDRESS 2008 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D-85064 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 31 D 85064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 504 E 26th " St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Kelley

(a) Residence No. 504 E 26th " St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie B Kelley

6-DATE OF BIRTH (month, day and year): Jan 7-1890

7-AGE. 34 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Motorman
(b) General nature of Industry, business, or establishment in which employed (or employer): Electric Line
(c) Name of employer: W. B. & A. Ry

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.
10-NAME OF FATHER: Franklin P Kelley
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland
12-MAIDEN NAME OF MOTHER: Martha J Schultz
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Edw C Tipton
(Address): Hampstead Md

15- Filed MAR 21 1924 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (Month) March 20/24

17- I HEREBY CERTIFY, That I attended deceased from January 28th 1924. to March 20th 1924. that I last saw h.. alive on March 20th 1924. and that death occurred, on the date stated above, at 5.40P m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Mengert Jones M. D.

3/20/ 1924 (Address) 401 E. 33rd St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL: Grace Church Balto Co — DATE OF BURIAL: March 1924

20-UNDERTAKER, Wm J Hickert & Sons — ADDRESS North & Penna Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85065

CERTIFICATE OF DEATH.

161-001 D 85065

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 President St.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adler

(a) RESIDENCE. NO. 231 President ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Frank Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Kletzsreider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Frank Adler
(Address) 231 President St

15 Filed MAR 21 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1924, to March 20, 1924, that I last saw h[illegible] alive on March 19 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ mos Baby)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Milton H. Cummins M. D

3/20 1924 (Address) 3 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Mar 21 1924
20 UNDERTAKER	ADDRESS
Geo M. Smith Son	811 W Lee

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85066

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE—(No. 935 S Clinton St., 7th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Bonner,

(a) RESIDENCE NO. 935 S Clinton St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex. J. Bonner

6 DATE OF BIRTH (month, day, and year) Aug 10-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housekeeper 037
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John Cotter

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Margaret Bonner
(Address) 935 S Clinton St.

15 Filed MAR 21 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Paralysis

duration yrs. mos. ds.

(Signed) Geo Edwin Blades M. D.
(Coroner.)

3/21/24, 192 (Address) 436 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL March 22 1924

20 UNDERTAKER Geo M Fink & Son — ADDRESS 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Adam. Hanitsch

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85067

91-1924 D 85067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 W Lexington ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Hanitsch

(a) RESIDENCE. NO. 906 W Lexington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Emma Hanitsch

6 DATE OF BIRTH (month, day, and year) Dec 11- 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Heinrich Hanitsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Abt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Hanitsch
(Address) 906 W. Lexington St.

15 Filed MAR 21 1924 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1924, to Mar 20, 1924, that I last saw him alive on Mar 19, 1924, and that death occurred, on the date stated above, at 3.9 a. m.

The CAUSE OF DEATH* was as follows:

Toxaemia, Gangrene left foot to ankle

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly M. D.

Mar 21 1924 (Address) 3027 W Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF ~~BURIAL~~ CREMATION ~~OR REMOVAL~~ London Park

DATE OF BURIAL March 24 1924

20 UNDERTAKER C. W. Dill.

ADDRESS 3109 Fredk. Ave:

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 85068

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85068

CERTIFICATE OF DEATH.

74-001

14

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 Bolton St. ST. ..... WARD)

2-FULL NAME Rebecca J. Broomell

(a) RESIDENCE. NO. 2128 Bolton ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Seneca P. Broomell

6 DATE OF BIRTH (month, day, and year) Sept. 22 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0 37

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Jonah H. Lupton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lydia Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Burchell

(Address) 2128 Bolton St

15 Filed MAR 21 1924, 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1924, to March 20, 1924, that I last saw h 92 alive on March 19, 1924, and that death occurred, on the date stated above, at 3 40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) A. F. Robinson, M. D.

3/20. 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Greenmount Cemetery — Mch. 22 1924

20 UNDERTAKER — ADDRESS

Chas. E. Franck — 807 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85069

31

CERTIFICATE OF DEATH.

D 85069

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 3 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John Douglas

(a) RESIDENCE NO. 817 E. Baltimore St. Pratt or ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W
5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: 087
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Hospital Information
(Address) Carline and Bolton

Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1924, to March 19, 1924, that I last saw him alive on March 19, 1924, and that death occurred, on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tbc

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis?

(Signed) John A. Schenck, M. D.
, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL
DATE OF BURIAL: 19

20 UNDERTAKER
ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85070

CERTIFICATE OF DEATH.

24-006 85070

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 W. North Ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Coale

(a) Residence No. 714-W-North Ave St., 13 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? 67 yrs. 4 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. M. Coale

6-DATE OF BIRTH (month, day and year) Oct-24-1856

7-AGE, 67 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Francis T. Rodenmeyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Mary Elizabeth Howard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mrs. Marie Rodenmeyer Sister

(Address) 714-W-North Ave

15- Filed MAR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 19 1924

17- I HEREBY CERTIFY, That I attended deceased from April, 19 21, to Mar 19, 19 24

that I last saw h.. alive on Mar 19, 19 24

and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 3 yrs. + mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McAlroy M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL, Mar 21 19 24

20-UNDERTAKER, [illegible] & MOWEN COMPANY WILLIAM E. WOODEN, Successor — ADDRESS 108 W NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho in plain terms, so that it may be properly classified. Exact statement of OCCUPA instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85071

99-902 D 85071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 North Ave (W. Mt. Hyd.) ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Amelia V Bennett

(a) RESIDENCE NO. 127 North Ave ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? 83 yrs. 11 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of D. Emory Bennett

6 DATE OF BIRTH (month, day, and year) April 5 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) ..... none

(c) Name of employer ..... none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Blake

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Woodward

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mrs. M. Alice Bennett (Daughter-in-Law)

(Address) 2007 E 30 St.

15 Filed MAR 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 19, 1924, that I last saw her alive on March 19, 1924, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) William J Todd, M. D.

, 19 (Address) 1111 Washington

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mullen Cemetery

DATE OF BURIAL March 1924

20 UNDERTAKER J. MOWEN COMPANY Richard F. Wooden, Successor

ADDRESS 108 W. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85072

CERTIFICATE OF DEATH.

90 B 85072

1-PLACE OF DEATH Talbot Apartment

CITY OF BALTIMORE: (No.) Lafayette & Charles ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Parker

(a) RESIDENCE NO. Lafayette & Charles ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Parker

6 DATE OF BIRTH (month, day, and year) Dec 19 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Hen. Warwick

11 BIRTHPLACE OF FATHER (city or town) England

(State or country)

12 MAIDEN NAME OF MOTHER Mahan

13 BIRTHPLACE OF MOTHER (city or town) France

(State or country)

14 Informant Mary A. Michael

(Address) Talbot Apartments

15 DATE MAR 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17

I HEREBY CERTIFY, That I attended deceased from 2 hours, 1924, to , 1924,

that I last saw her alive on March 19, 1924,

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

4 years (duration) 4 yrs. — mos ds.

CONTRIBUTORY (Secondary) Shock (duration) one hour yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Charles S. Woodruff M. D.

, 19 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL [redacted] 19 24

20 UNDERTAKER [illegible] ADDRESS Balto Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85073

CERTIFICATE OF DEATH.

161-001 D 85073

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 8 WARD)

2-FULL NAME Annie C. Kennell

(a) RESIDENCE NO. 1402 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar 1/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓			18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... :one
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) ..... Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Kennell

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ginther

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Louis Kennel
(Address) 1402 N. Chester St

15 MAR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Prematurity

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Sollers (Coroner.), M. D.

Mar 20/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL March 21 1924

20 UNDERTAKER Robt J. Turner & Sons — ADDRESS 442 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85074

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 85074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1018 Forrest St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Bridget Kelly

(Residence in Baltimore: No. 1018 Forrest St.; 60 yrs., ...mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1..... (Year)

7-AGE.	If LESS than 1 day,
75 yrs. ....mos. ....ds.	....hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired 07
(b) General nature of industry, business, or establishment in which employed (or employer)..... Housework

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Kelly

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary McDonnell

(Address) 1018 Forrest St

15- MAR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March 19, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Hepburn M. D. (Coroner.)

Mar 20 1924 (Address) 701 E Clay St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral	Mar 22 1924

20-UNDERTAKER.	ADDRESS
J. C. Wachsfeld	914 Greenmount Ave

IMPORTANT: Every item should be carefully supplied. Name of deceased should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85075

CERTIFICATE OF DEATH.

100-001

D 85075

1-PLACE OF DEATH

City of BALTIMORE: (No. 5207 Greenmount Ave. 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Wm. C. Mourus

(a) Residence No. 5207 Greenmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Sue B.

6-DATE OF BIRTH (month, day and year): May 3, 1845

7-AGE: 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Commn. Mch

(b) General nature of Industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer:.....

9-BIRTHPLACE (city or town) (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Wm. C. Mourus

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Mary Lowell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.

14-

(Informant): Mrs. M. Murphy

(Address): 5207 Greenmount Ave

15-

Filed....., 192... ROBERT R. KRAUTER, Registrar.

MAR 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch 20. 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 28, 1923, to Mch 20, 1924,

that I last saw h.... alive on Mch 19, 1924,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Superinduced by

Pneumonia

(Duration) ....yrs. 3 mos. 22 ds.

CONTRIBUTORY (Secondary): Bronchial Pneumonia

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? at Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. Duncan, M. D.

Mch 20, 1924 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park	Mar. 22, 1924
20-UNDERTAKER.	**ADDRESS**
J. C. Wakefield	914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85076

D 85076

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3228 Elmley Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. McCarthy

(a) Residence No. 3228 Elmley Ave St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 7th 1922

7-AGE. 1 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS

10-NAME OF FATHER, Leo. T. McCarthy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Katharine McCoy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Mrs. Leo T. McCarthy

(Address) 3228 Elmley Ave

15- Filed MAR 21 1924 192... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 21st 1924

17- I HEREBY CERTIFY, That I attended deceased from March 19 1924 to March 20 1924 that I last saw h-r alive on March 20 1924 11P and that death occurred, on the date stated above, at 7 A March 21.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute - with sudden decompensation

not known. Symptoms for (Duration) ---- yrs. ---- mos. 3 ds.

CONTRIBUTORY (Secondary) Acidosis, vomiting, dehydration

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Lawson Hilkins M. D

Mar. 21, 1924 (Address) 1014 St Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross Cemetery Philadelphia Pa.	March 22nd 1924
20-UNDERTAKER,	ADDRESS
Henry Hoeck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-21-E.B.R.S.-400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85077

CERTIFICATE OF DEATH.

X45

D 85077

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St Agnes Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Morgan

(a) Residence No. 1415 E Pratt St., Ward Richmond Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~ Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Dora Morgan

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 47 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stock Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). " "

12-MAIDEN NAME OF MOTHER. " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " "

14-Informant Mrs Dora Morgan

(Address) 1415 E Pratt St

15-Filed MAR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 20 1924

17-I HEREBY CERTIFY, That I attended deceased from March 3 1924 to March 20 1924

that I last saw h-- alive on March 20 1924

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Mesentery

? ? ?

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Goldman M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Allen Mt Carmel — DATE OF BURIAL. 3-22 1924

20-UNDERTAKER. Jas Lewis — ADDRESS 1439 E Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Hattie Jenkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-0 01 ✓

D 85078

CERTIFICATE OF DEATH.

D 85078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 24 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hattie Jenkins.

(a) RESIDENCE NO. 632 Aull St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Jenkins

6 DATE OF BIRTH (month, day, and year): 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John Hagerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Hospital Records.

15 MAR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/20/24. 19

17 I HEREBY CERTIFY, That I attended deceased from 2/28/24, 19 ..... to 3/20/24. 19 .....

that I last saw h— alive on 3/20/24. 19 .....

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Subacute).

..... (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia. (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Necropsy

(Signed) H. W. McCoy, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: Mar 24th 1924

20 UNDERTAKER: Leo G. Crook

ADDRESS: North Harford Ave

Clever ✓

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85079

153

CERTIFICATE OF DEATH

1-PLACE OF DEATH Baltimore Eye, Ear & Throat Hosp

CITY OF BALTIMORE: (No. 625 N. Franklin ST.: N WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Asa Cleaver

(a) RESIDENCE. No. 906 S. 6th St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8th 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Copper Works (Canton)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Joseph Thos Cleaver

11 BIRTHPLACE OF FATHER (city or town) Round Hill Pa. (State or country) Adams

12 MAIDEN NAME OF MOTHER Barbara May Hilliman

13 BIRTHPLACE OF MOTHER (city or town) May Town (State or country) Lancaster Co Pa.

14 Informant Mrs Barbara May Cleaver (Address) 906 S. 6th St

15 Filed MAR 21 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1924, to March 19 1924, that I last saw him alive on March 19 1924, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

(duration) yrs. 1 mos. 27 ds.

CONTRIBUTORY (Secondary) Meningitis (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? 906 S. 6th St

Did an operation precede death? Yes Date of Jan 25

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Usual)

(Signed) J. W. Downey, M. D.

19 (Address) 524 N. Charles St

3-20-24 Per R. Young M.D.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem DATE OF BURIAL Mar. 21 1924

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Dallas St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85080

CERTIFICATE OF DEATH.

D 85080

161-86

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 S. Fulton Ave. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Beatrice Pedone

(a) RESIDENCE NO. 7 S. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs or min.
√				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Leo Pedone Jr.

11 BIRTHPLACE OF FATHER (city or town) Phila (State or country) Pa.

12 MAIDEN NAME OF MOTHER Lillian B. Wilson

13 BIRTHPLACE OF MOTHER (city or town) Rockport (State or country) Mass

14 Informant Leo Pedone Jr. (Address) 7 S. Fulton Ave.

15 MAR 21 1924 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 19 24

17 I HEREBY CERTIFY, That I attended deceased from March 20, 19 24 to March 21, 19 24.

that I last saw her alive on March 21, 19 24.

and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cookson M. D.

3/21/1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 22 1924
20 UNDERTAKER	ADDRESS
Harry R. Comerford	4204 Edgewood Ave

B.—WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85081

CERTIFICATE OF DEATH.

38

8.05 pm

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 Edmondson ave ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Edward murray

(a) RESIDENCE No 1711 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ruth E. murray

6 DATE OF BIRTH (month, day, and year) July 20, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Howard County Maryland

PARENTS

10 NAME OF FATHER William Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Maryland

12 MAIDEN NAME OF MOTHER Alana Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ruth E. Murray

(Address) 1711 Edmondson Ave

15 Filed MAR 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 29, 1923, to March 19, 1924, that I last saw h alive on March 19, 1924, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurism

(duration) 4 yrs. — mos. 0 ds.

CONTRIBUTORY (Secondary) Hemorrhage from rupture of aneurism

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. W. Hymmelbaugh M. D.

3/20, 1924 (Address) 3002 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL March 19 1924

20 UNDERTAKER John B. Spence — ADDRESS 1325 N Caroline St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85082

CERTIFICATE OF DEATH.

D 85082

1-PLACE OF DEATH

City of BALTIMORE: (No. 3016 McElderry St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Kenneth Seits

(a) Residence No. 3016 McElderry St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 4/23

7-AGE.	If LESS than 1 day,
yrs. 10 mos. 11 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, Raymond Seits

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ill.

12-MAIDEN NAME OF MOTHER Selma Werneth

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) Selma Werneth

(Address) 3016 McElderry

15- Filed MAR 27 1924 19?? Robert P. Harrison Registrar.

Curtis Ferrell Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/20/24

17- I HEREBY CERTIFY, That I attended deceased from March 20 1924 to March 21 1924

that I last saw h[illegible] alive on March 21 1924

and that death occurred, on the date stated above, at 7.40 p. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. Artigiani M. D

19 (Address) 294 N Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn	3/22 1924
20-UNDERTAKER. Philip Henry	ADDRESS 1006 Orleans

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85083

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 E. 28th St., 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma L. Wambach

(a) RESIDENCE No 1402 Darley ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed~~, or Divorced ~~(write the word)~~: Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 16/52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Emanuel Wambach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John E. Roney
(Address) 1402 Dailey ave

15 Filed ..., 192 ... Robert P. Harrison, Registrar

MAR 21 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Polen, M. D. (Coroner.)

Mar 20/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem — DATE OF BURIAL 3/22 1924

20 UNDERTAKER: Philip Henry — ADDRESS 206 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN sho
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Q
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85084

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1B 2 Jenkins alley ST., 11 WARD)

REGISTERED NO. 164

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dyott

(a) RESIDENCE NO. 1132 Jenkins Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: African

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1827

7 AGE: 97 Years, Months, Days. If LESS than 1 day, hrs. or min.

As nearly as I can reckon she was a slave of my Grand Father who died in 1843. Mother said she was 16 yr. when he died.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Had been a cook

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): near Centreville Md.

PARENTS

10 NAME OF FATHER: I do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Centreville Md

12 MAIDEN NAME OF MOTHER: Do not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Centreville.

14 Informant: Saml. T. Earle M.D.

(Address): 1431 Lowndes Ave.

15 Filed: Robert P. Harrison, Registrar

MAR 21 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1924

17 I HEREBY CERTIFY, That I attended deceased from 1900, to at intervals 1924, that I last saw her alive on March 20th 1924, and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age—senile dementia

etc.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Saml. T. Earle, M. D.

, 19 (Address) 1431 Lowndes Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: 3-22 1924

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85085

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85085

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Montague

(a) Residence No. 427 N. Pine St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1844

7-AGE: 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-(Informant): Municipal Hospital

(Address):

15-Date MAR 21 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-14-24

17- I HEREBY CERTIFY, That I attended deceased from 3-11, 1924 to 3-19, 1924

that I last saw h[illegible] alive on 3-19, 1924

and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Asthenocardia

Chronic myocarditis

Myocardial degeneration

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude T. Drane M. D.

3-19, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 3-22, 1924

20-UNDERTAKER: David Carter — ADDRESS 916 Penna ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85086 ✓ D 85086

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1920 Walbrook Ave ST., 5 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerald Chaffman

(a) RESIDENCE NO. 1920 Walbrook Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 3/23/1921

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	3	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Benj F. Chaffman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Fraze

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant B. F. Chaffman
(Address) 1920 Walbrook Ave

15 Filed ..... 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1924, to March 20, 1924, that I last saw him alive on March 19, 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia due to
impacted feeding
(duration) yrs. mos 8 days

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Fred C Jewett, M. D.

March 20, 1924 (Address) 25 E Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL 3/22/1924

20 UNDERTAKER George D. Pudlin ADDRESS 35 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 21 1924

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85087 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D 85087

CERTIFICATE OF DEATH. X 90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 212 S. Paca 1 St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elenora John

(a) Residence No. 212 S. Paca 1 St., Ward Wash. D.C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 weeks How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, ~~Widowed~~, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Steve Steve John

6-DATE OF BIRTH (month, day and year) July 1869

7-AGE. 55 yrs. 8 mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer). None
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Serbia

PARENTS.
10-NAME OF FATHER, Guzie Marinco
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Serbia
12-MAIDEN NAME OF MOTHER, Catana Marinco
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Serbia

11- (Informant) Steve John
(Address) 212 S. Paca

15- Mar 21 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 21 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to March 17 1924
that I last saw h... alive on March 17 1924 10
and that death occurred, on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Chronic valvular
Heart Disease

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) [illegible] M. D
3/21 1924 (Address) 638 Wash D.C.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION or REMOVAL. Mt Olivet Washington D.C. — DATE OF BURIAL. Mar 24 1924

20-UNDERTAKER. Jos Jacobs & Son — ADDRESS 217 S. Paca

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85088

CERTIFICATE OF DEATH.

90 D 85088

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 W Belvedere Ave ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Busch

(a) RESIDENCE NO. 410 Belvedere Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Busch

6 DATE OF BIRTH (month, day, and year) Jan 1st Unknown 1844

7 AGE	Years	Months	Days
	80		

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salt Lake Utah

PARENTS

10 NAME OF FATHER Thos Riggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A Barrangan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Irene Robins (Address) 410 W. Belvedere Ave.

15 Filed MAR 2 1924 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1923 to Mch 29 1924

that I last saw her alive on Mch 18 1924

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? — no

What test confirmed diagnosis? Clinical

(Signed) Charles J Wells M. D.

19 (Address) 2 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 3/22 1924

UNDERTAKER J J Gahagan & Sons

ADDRESS 138 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85089

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3134 Cedar Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M Sweetmon

(a) Residence No. 3134 Cedar Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Laura Sweetmon

6-DATE OF BIRTH (month, day and year) April 20 1863

7-AGE, 60 yrs. 11 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Anna R Williams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) George M Sweetmon (Address) 3134 Cedar Ave

15- Robert P. Harrison, Registrar.

MAR 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 20 1924

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to March 20 1924, that I last saw him alive on March 20 1924 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral confusion

(Duration) ... yrs. ... mos. 1 ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

March 21 1924 (Address) 342 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Marys Hampden	March 24 24
20-UNDERTAKER, Cohenouvelt & Son	ADDRESS 3617 Chestnut Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85090 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85090

003

CERTIFICATE OF DEATH.

15 145

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2111 Herbert St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.. Lillian M Arbaugh

(a) Residence No. 2111 Herbert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of ~~Wife~~ Robert H Arbaugh

6-DATE OF BIRTH (month, day and year) Apl 22 1896

7-AGE, 27 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Fredrick Lober

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Horsman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Robert H Arbaugh

(Address) 2111 Herbert St

15- Filed Mar 22 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 20th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 13, 1924, to March 20, 1924.

that I last saw h[illegible] alive on March 19, 1924

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia following Childbirth on March 13/24

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paresis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Fiethkoff, M. D.

, 19 (Address) 807 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Dr. Mary Harrison

DATE OF BURIAL, March 22 1924

20-UNDERTAKER,

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 22 1924

(Stephen Shrieves)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85091

D 85091

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 555 W Hoffman ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Schrieves

(a) RESIDENCE. No. 555 W Hoffman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Dealer. 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Shrieves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Dixon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14

Informant (Address) Annie Frazier 555 W. Hoffman St.

15 [illegible] 19

Registrar

Burial Permit Clerk.

MAR 2 21924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 19, 1924, to March 19, 1924, that I last saw h[illegible] alive on March 19, 1924, and that death occurred, on the date stated above, at 8 A, m.

The CAUSE OF DEATH* was as follows: Cardiac Dilation Collapse

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Characteristic Symptoms

(Signed) Arthur Lee, M. D.

March 20 24 (Address) 712 S Wash Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn. Cem.	3/23 1924
20 UNDERTAKER Samuel H Hawley	ADDRESS 1378 Biddle

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–12-23-21–E.B.R.S.–400 Blks.

D 85092

HEALTH DEPARTMENT—CITY OF BALTIMORE

65 D 85092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, 2300 Mt Royal Terrace (No.) 13 (Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H Hooper

(a) Residence No. 2300 Mt Royal Terrace Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed or divorced HUSBAND of (or) WIFE of Gertrude Lipp Hooper

6-DATE OF BIRTH (month, day and year) Mch 21 1857

7-AGE 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 043

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Merchant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Thomas H. Hooper

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Young

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Gratitude L. Hooper

(Address) 2300 Mt Royal Terrace

15 Filed..... Robert P. Harrison, Registrar.

MAR 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1923 to March 21 1924

that I last saw h[e] alive on March 20 1924

and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) — yrs. 6 mos. 14 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ?

(Signed) Jefferie Rucker M. D.

3/21, 1924 (Address) 1846 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount DATE OF BURIAL. March 24 1924

20-UNDERTAKER. John O. Mitchell ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85093 ✓ D 85093

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 N. Bethel ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jackson John Hill

(a) RESIDENCE NO. 506 N. Bethel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 20 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Hill

6 DATE OF BIRTH (month, day, and year) 6-12-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Goldsburg N. C.

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Hattie Hill
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Rebecca Hill (Address) 506 N. Bethel St.

15 MAR 22 1924 . 19 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-10-1924, to 3-19-1924, that I last saw him alive on 3-18-1924, and that death occurred, on the date stated above, at 3,45 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvulitis

(duration) 5 yrs. — mos ... ds.

CONTRIBUTORY (Secondary) Interstitial nephritis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Garges M. D.

3-[illegible]-19[illegible] (Address) 611 N Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Mch 22 1924
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1302 Jefferson

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85094

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 85094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Payson ST., 15 WARD)

2-FULL NAME Mrs. Catherine Neser

(a) RESIDENCE NO. 1606 North Aorst. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Charles Neser

6 DATE OF BIRTH (month, day, and year) Mar. 21 - 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Daley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant J. Charles Neser

(Address) 1606 N. North Ave

15 Robert P. Harrison, 19

Registrar

Burial Permit Clerk.

MAR 22 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27th, 1924, to March 20th, 1924,

that I last saw he alive on March 20th, 1924,

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & X-ray finds

(Signed) H. McDowell M. D.

3/20/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar. 24 1924
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 N. North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35095

D 85095

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Madison Ave ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Kirwin

(a) RESIDENCE NO. 813 Madison Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Patrick Kirwin

6 DATE OF BIRTH (month, day, and year) Feb 29th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Kirwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Ellen McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Freeman

(Address): 813 Madison Ave

15 Filed ..... 19 ..... Registrar

MAR 2 21924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 19 24

17 I HEREBY CERTIFY, That I attended deceased from March 19 19 24 to March 21 19 24

that I last saw h alive on March 21 19 24

and that death occurred, on the date stated above, at 10.10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 3 ds.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J Wm Inskeep M. D.

, 19 (Address) 3 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 3-24 1924

20 UNDERTAKER: Henry W Jenkins & Sons Co

ADDRESS: Catonsville a Ordway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85096

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85096

74-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 N Pratt ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Feeley

(a) RESIDENCE NO. 1324 N Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret Feeley

6 DATE OF BIRTH (month, day, and year) May 15. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	74		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R R

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Feeley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Margaret Feeley

(Address) 1324 N Pratt Street

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

Burial Permit Clerk.

MAR 22 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 9, 1924 to Mar 21, 1924, that I last saw h.. alive on Mar 21, 1924, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edw J. Cookson M. D.

3/22, 1924 (Address) 21 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 3/24 1924

ADDRESS

20 UNDERTAKER John J Fields 1200 W Lombard

IN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85097

D 85097

CERTIFICATE OF DEATH.

4177

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eric Sundren

(a) RESIDENCE NO. Hotel Eldred ST. Sparrows Point Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Labober (Stillers)
(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel
(c) Name of employer: Co.

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10 NAME OF FATHER: A. Sundren

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Augusta Olson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Dr. Shafer
(Address): Sparrows Pt. Md.

15 Filed MAR 22 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-Empyema due to perforation of oesophagus caused by accidently swallowing lye (boiler Mixture at Steelton) (duration) yrs. V mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

on Nov Page

(Signed) J S H Paul, M. D.
(Coroner.)

Mar 22/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Mar 22 1924

20 UNDERTAKER: John F Kenny — ADDRESS: 715 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 85098

CERTIFICATE OF DEATH

15

D 85098

REGISTERED No. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 So Clinton ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kenneth L. Foster

(Residence in Baltimore: No. 131 So Clinton St St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
M	white	S

6-DATE OF BIRTH March 20 (Month) (Day), 1924 (Year)

7-AGE X yrs. X mos. X ds. If LESS than 1 day, 1 hrs., or X min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE (State or country): Highlandtown Md

PARENTS

10-NAME OF FATHER: Edward L. Foster

11-BIRTHPLACE OF FATHER (State or country): Balto Md

12-MAIDEN NAME OF MOTHER: Blanche Swanner

13-BIRTHPLACE OF MOTHER (State or country): Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward L. Foster

(Address) 131 So Clinton St

15- Robert F. Garrison

Filed ..... 191 ..... Burial Permit Clerk. REGISTRAR

AR 2 2192[illegible]

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH March (Month) 20 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to, March 20 1924 that I saw h[illegible] alive on March 20 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation Heart

(Duration) X yrs. X mos. 1 ds.

Contributory (SECONDARY) Congenital Heart

(Duration) X yrs. X mos. 1 ds.

(Signed) Dr L. Grinnan M. D.

[illegible] 20 ,191 24 [Address] 248 So 3084

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Schwartz Cem. DATE OF BURIAL: March 22, 1924

20-UNDERTAKER: Lilly & Zile ADDRESS: 403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85099

CERTIFICATE OF DEATH.

D 85099

129

1-PLACE OF DEATH Colonial Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1122 N. Mount. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Hutson

(a) RESIDENCE NO. 825 S. Linwood ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hutson

6 DATE OF BIRTH (month, day, and year) Oct. 20-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Krauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant (Address) Joseph D. Rainer 411 N. Stricker St

15 Filed MAR 22 1924 Robert P. Harrison, Registrar

Daniel Ferrell Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 20, 1924, that I last saw h alive on March 20, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? 825 S Linwood Ave.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Dr. A. A. Sussman M. D.

, 19 (Address) 1122 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	March 24 1924
20 UNDERTAKER	ADDRESS
Lilly & Fiske	403 W Mt Royal Ave

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(See Letter in file April 11-1924 from Dr. Fisher)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85100 — D 85100

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2124 Fleet St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Paul Wlodarski

(a) Residence No..... 2124 Fleet St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~Widow of~~ Sophia Wlodarski

6-DATE OF BIRTH (month, day and year) May 20 1891

7-AGE. 32 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Labor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country)..... Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country)..... Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)..... Poland

14- (Informant) Mrs. Sophia Wlodarska

(Address) 2124 Fleet Street

15- Filed MAR 22 1924 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 22 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2 1923 to Mar 20 1924, that I last saw h. alive on Mar 18 1924 and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ~~1~~ yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) [illegible] M. D.

(Address) 332 S Patterson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	March 24 1924
20-UNDERTAKER.	ADDRESS
Lahn & Weber	1803 Bank

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

—WRITE PLAINLY, WITH UNFADING INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85101

B 85101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1117 Mc Culloh St. (ST.:) 11 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Johnson

(a) RESIDENCE. No. 1117 Mc Culloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary W. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Emma Boyer

(Address) 1624 Druid Hill Ave

15 Robert F. [illegible]

MAR 22 1924 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21 1924

17

I HEREBY CERTIFY. That I attended deceased from 3/1, 1924, to 3/20, 1924, that I last saw h[illegible] alive on 3/20, 1924, and that death occurred, on the date stated above, at 2.40 A. m.

The CAUSE OF DEATH* was as follows:

Pleurisy 4/7 Bronchitis

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) 5 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. H. Tilden, M. D.

19 (Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md Auburn Cem	3-24 1924
20 UNDERTAKER	ADDRESS
George T. A. Gibson	1735 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85102 | CERTIFICATE OF DEATH. | X 117 D 85102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanley Lee Colson

(a) RESIDENCE NO. Ellicott City Md. WARD Ellicott City Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 17 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rockland Howard Co.

PARENTS

10 NAME OF FATHER Geo W. Colson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D. C.

14 Informant Hospital Records (Address)

15 Filed MAR 22 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21-1924

17 I HEREBY CERTIFY, That I attended deceased from Mch 4 19 24, to Mch 21 19 24, that I last saw h[illegible] alive on Mch 21 19 24, and that death occurred, on the date stated above, at 1[illegible] am.

The CAUSE OF DEATH* was as follows: Acute Appendicitis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis & Septicemia

(duration) ... yrs. ... mos. 19 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? yes Date of Mch 4/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R J Fyfe Jr M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Good Shepherd Cemetery Howard Co Md.	Mch 23 1924
20 UNDERTAKER	ADDRESS
Scott M. Starr	Ellicott City Md

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85103

HEALTH DEPARTMENT—CITY OF BALTIMORE

1000 D 85103

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Scott ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doras Frampton

(a) RESIDENCE No. 1014 Scott ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24th 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER David Frampton

11 BIRTHPLACE OF FATHER (city or town) Tilghman (State or country) Md

12 MAIDEN NAME OF MOTHER Ama Wingate

13 BIRTHPLACE OF MOTHER (city or town) Worchester (State or country) Mass.

14 Informant (Address) 1014 Scott St

15 Filed . 19 Robert P. Warfield, Registrar

Burial Permit Clerk.

MAR 22 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 22. March 1924

17 I HEREBY CERTIFY, That I attended deceased from 13 March, 1924, to 21. March, 1924, that I last saw her alive on 21. March, 1924, and that death occurred, on the date stated above, at 1.44 a.m.

The CAUSE OF DEATH was as follows:

Double Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis?

(Signed) Dr. Vincent Culotta, M. D.

. 19 (Address) 811 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Mar 22 1924

20 UNDERTAKER Wm C. Butler

ADDRESS 2334 Jeff St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85104

CERTIFICATE OF DEATH.

159-00-2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 798 Wilcox St., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby Mordi Fabrina

(a) RESIDENCE NO. 798 W Cross ST., 21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (Write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 21-24

7 AGE Years 8 Months Days If LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Mordi Fabrina

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Katherine Doot

13 BIRTHPLACE OF MOTHER (City or town) Baltimore Md

(State or country)

14 Informant Kate Mordi Fabrina

(Address) 798 W Cross St

15 MAR 22 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1924

17 I HEREBY CERTIFY, that I attended deceased from Mar 21 1924 to Mar 22 1924

that I last saw her alive on Mar 21 1924

and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. C. Edmunds M. D.

, 19 (Address) 11 N. Newkirk St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL Mar 22nd 1924

20 UNDERTAKER Leo G. Cook — ADDRESS North & Eutaw

Burial Permit Clerk

M. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85105

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-08 1 85105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 906 S. Ellwood St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Backus.

(a) Residence No. 906 S. Ellwood St., 1 Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 20 Moments ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 21st 1924

7-AGE. [illegible] mos. ..... ds. If LESS than 1 day, ... hrs. or 20 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Wm E. Backus

11-BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or Country).

12-MAIDEN NAME OF MOTHER, Carrie Hubbard

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or Country).

14-

(Informant) William E. Backus

(Address) 906 S. Ellwood Ave

15-

MAR 22 1924 Robert P. Harrison, Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21st 1924

17- I HEREBY CERTIFY, That I attended deceased from

on March 21, 1924 to ..... 19.....

that I last saw h.. alive on March 21 1924

and that death occurred, on the date stated above, at 8 57 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 mo. Uterogestation

(Duration) ..... yrs. ..... mos. 1/2 hr.

CONTRIBUTORY
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? — no

What test confirmed diagnosis? —

(Signed) M J McAvoy M. D.

3/27 1924 (Address) 834 S. Ellwood Ave

*State the **Disease Causing Death**, or In deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sacred Heart Cem	March 25th 1924
20-UNDERTAKER.	**ADDRESS**
Lilly - Zeller	4038 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.N.S.—400 Blks.

D 85106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85106

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2320 W. North Ave. St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Goldenberg

(a) Residence No. 2320 W. North Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? Unknown ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Goldenberg

6-DATE OF BIRTH (month, day and year) Jany. 3, 1847

7-AGE. 77 yrs. 2 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED. 1 043

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant). Mr. Eli Goldenberg

(Address) 2320 W. North Ave.

15- Filed MAR 22 1924, 192. Robert P. Harrison, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/22/24.

17- I HEREBY CERTIFY, That I attended deceased from Nov 17, 1923, to March 22, 1924, that I last saw him alive on March 21, 1924, and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Sclerosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) E. Lansdowne Hull M. D

March 1924 (Address) 817 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Hebrew Cem.	3/[illegible], 19....
20-UNDERTAKER. David Sondheim	ADDRESS. 118-20 W. Mt. Royal Ave.

3-WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 85107

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85107

CERTIFICATE OF DEATH.

100-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N Carey ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Barnes.

(a) RESIDENCE NO. 1018 N Carey ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 - 20

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	4	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer .....

9 BIRTHPLACE (city or town) Bath
(State or country)

PARENTS

10 NAME OF FATHER Arthur J. Barnes

11 BIRTHPLACE OF FATHER (city or town) Georgia
(State or country)

12 MAIDEN NAME OF MOTHER Martha E Taylor

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Arthur J Barnes
(Address) 1018 N Carey

15 Filed ....., 192.. Robert P. Harrison, Registrar

AR 22 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Res death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap Tonsilitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred Emil Wales, M. D.
(Coroner)

3/22/24, 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry	Mch 22 '24
20 UNDERTAKER	ADDRESS
Jane H Chase Son	1400 Mad.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign. Every line. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85108

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Hudson St ST.: W WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gudzientowz

(a) RESIDENCE. No. 3208 Hudson ST. / WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank ~~Gudzientowz~~ Bonk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ~~Rosa Gudzientowz~~ Rosa Banach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michal Gudzientowz
(Address) 3208 Hudson St

MAR 22 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 12t 1923 to Mch 20th 1924

that I last saw her alive on Mch 19th 1924

and that death occurred, on the date stated above, at 12 15 p m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberc

ulosis (duration) — yrs 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Helagus Rosenau M. D.

(Address) 111 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Mar 24 1924
20 UNDERTAKER	ADDRESS
Stecker & Fialkowski	

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85109

CERTIFICATE OF DEATH.

32 D 85109

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hosp. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Parker.

(a) Residence No. 259 Patapsco St. Westport Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 13, 1903

7-AGE. 20 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Glass worker

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Md

9-BIRTHPLACE (city or town) (State or Country).

PARENTS.

10-NAME OF FATHER, Wm Parker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER, Kate Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Wm Parker

(Address) 259 Patapsco St

15- Westport. Md

Filed ..... 192.....

MAR 23 1924

ROBERT R. KRAUTER, Recorder.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mch 17 19 24 to Mch 21 19 24

that I last saw him alive on Mch. 21 19 24

and that death occurred, on the date stated above, at 5-32 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY — (Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Puncture

(Signed) V. Goldman M. D.

19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery

DATE OF BURIAL. Mar 24 1924

20-UNDERTAKER. Nelson E. Stiles

ADDRESS 320 Md Ave Westport

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85110

CERTIFICATE OF DEATH.

90

B 85110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2905 Hudson ST.; (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Nordstrock

(a) RESIDENCE. NO. 2905 Hudson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Ernest Nordstrock

6 DATE OF BIRTH (month, day, and year): Mar 14, 1878

7 AGE — Years: 46 — Months: — — Days: 6 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Filmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ernest Nordstrock
(Address) 2905 Hudson St

15 MAR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1924 to Mar 20 1924

that I last saw her alive on Mar 20 1924

and that death occurred, on the date stated above, at 7-0 a.m.

The CAUSE OF DEATH* was as follows: Coronary Embolism

Arteriosclerosis (duration) One yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis (duration) — yrs. — mos. One ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H L Rupard M. D

(Address) 5105 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	Mar 23 1924
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Lest St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85111

CERTIFICATE OF DEATH.

175 D 85111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 mc culloh ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Boston

(a) RESIDENCE NO. 1928 mc culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 4 1863

7 AGE: Years 60; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West River Md.

PARENTS

10 NAME OF FATHER: Benjiman Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan Warren

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Robert Boston 1928 Mc Culloch St

15 Filed MAR 23 1924 ROBERT R. KNAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 20 1924

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 20, 1924, that I last saw her alive on March 20, 1924, and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Ptomain Poison - due to Veal which was not well done. (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): mitral Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Wheeling, M. D.

3/24, 1924 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Galesville Md

DATE OF BURIAL: 3/25 1924

20 UNDERTAKER: Samuel Hanesley

ADDRESS 578 Pine St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85112 X 129 D 85112

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katie Strauss.

(a) RESIDENCE NO. Boom P.O., Maryland. ST., WARD Boom P.O. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Strauss

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Elya Leib Borodofsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1429 Eutaw St

15 Filed MAR 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to March 22, 1924, that I last saw her alive on March 22, 1924, and that death occurred, on the date stated above, at 4:40 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis & hypertension ending in uremia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & physical examination

(Signed) Henry V. P. Wilson Jr. M. D., M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 3-23 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1429 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

R 85113 — 49 — D 85113

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Shugar

(a) RESIDENCE NO. 320 S. Green ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rose Shugar

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Shugar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sara Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Record

(Address) Johns Hopkins Hospital

15 Filed MAR 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from June 31, 1924, to March 22, 1924, that I last saw h[illegible] alive on March 20, 1924, and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Lung tumor — over 7 mos

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Cemetery — DATE OF BURIAL 3/23 1924

20 UNDERTAKER Jack Levin — ADDRESS 1439 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Salyanik

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85114

90

D 85114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Salganik

(a) RESIDENCE NO. 2024 Eutaw Pl. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) Ex-Soldier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt and

PARENTS

10 NAME OF FATHER Wolfe Salganik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Baron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Hospital Records

15 FILED MAR 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/24

17 I HEREBY CERTIFY, That I attended deceased from 3/17/24, 19..., to 3/22/24, that I last saw h~~e~~ alive on 3/22/24, 19 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

Mitral Stenosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Golley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	3/25 19 24
20 UNDERTAKER	ADDRESS
Jack Levis	1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85115

CERTIFICATE OF DEATH.

74-001 ✓

D 85115

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 216 Richmond St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Smith

(a) Residence No. 216 Richmond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 67 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... Nil

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Pasik Weiner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Paul Smith

(Address) 2222 Washington Blvd

15- Filed MAR 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 23 to Mar 21 19 24

that I last saw h[illegible] alive on Mar 21, t9.....

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Paralysis & Arteriosclerosis

(Duration) 7 yrs. ....mos. ....ds.

t8-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Walter E. Tuckman M. D.

Mar 24 t9 24 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 3/25, 19 24
Fairview Memorial Park	
20-UNDERTAKER, Sol Levinson & Bro	ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85116

CERTIFICATE OF DEATH.

161-08 ✓ D 85116

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5005 Glenwood Ave. Raspeburg ST., 29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Virginia Wolfrum
Infant of William H. & Verlinda S. Wolfrum

(a) RESIDENCE. NO. 5005 Glenwood Ave. Raspeburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21st 1924

7 AGE ✓

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Wolfrum

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Verlinda S. Houston

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant William H. Wolfrum
(Address) 5005 Glenwood Ave. Raspeburg

MAR 23 1924

ROBERT R. KRAUSER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1924 to March 22, 1924, that I last saw h alive on March 22, 1924, and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(6 months)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Simms M. D.

3/22 1924 (Address) 4 Rock Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: March 24, 24

20 UNDERTAKER: Fred'k Leasa & Sons — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85117

CERTIFICATE OF DEATH.

129 D 85117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Apartment K. I. ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia C. Bolte

(a) RESIDENCE NO. Homewood Apt K I. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~
~~HUSBAND of~~ (or) WIFE of Henry Bolte

6 DATE OF BIRTH (month, day, and year) 1852 May 2

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71.	10	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Stalfort

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Klare

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Annette V. Koch
(Address) 1931 Eutaw Place

15 MAR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1923, to March 21, 1924,

that I last saw her alive on March 21, 1924,

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Uraemic Coma)

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 8 or 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pole, M. D.

, 19 (Address) 20 W. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gillenmount Cem	March 24 1924
20 UNDERTAKER	ADDRESS
J. H. Perkins & Son	Richard & College

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85118

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-00 ✓✓

D 85118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Chadford Apts

CITY OF BALTIMORE: (No. University Parkway ST. Roland Ave WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mitchell Froelicher

(a) RESIDENCE No. University Parkway ST. Roland Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Seeker

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Media Pa

PARENTS

10 NAME OF FATHER Hans Froelicher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Francis H Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant Mrs. F Froelicher

(Address) University Parkway & Roland Ave

15 Filed MAR 23 1924, 19.. ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1924

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923, to March 21, 1924, that I last saw him alive on March 21, 1924, and that death occurred, on the date stated above, at 12 25 P m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? microscopic ex. of a gland

(Signed) Louis F Hamburger, M. D.

Mch 22, 1924 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mch 24th 1924
20 UNDERTAKER Henry Jenkins Sons	ADDRESS Druid Hill & Mosher Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35119

CERTIFICATE OF DEATH.

D 35119

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... St., 13 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Kratz

(a) RESIDENCE NO. 744 W. North Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Wm Kratz

6 DATE OF BIRTH (month, day, and year) Jan 7, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Conrad H. Bockelmann

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Ann D. Bergman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant J. Wm Kratz
(Address) 744 W. North Ave.

15 Filed MAR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1924, to Mar. 21, 1924, that I last saw her alive on Mar. 21, 1924, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the pancreas
Umbilical Hernia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar 17, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Operative findings

(Signed) John M. Edmonds, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: March 24 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W North Ave

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85120

CERTIFICATE OF DEATH.

9 129

D 85120

1-PLACE OF DEATH

City of BALTIMORE: (No. 510 E. 21st, St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lohrfink

(a) Residence No. 510 E. 21st, St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-~~Single~~ Married, ~~Widowed,~~ or ~~Divorced.~~ (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Lohrfink

6-DATE OF BIRTH (month, day and year) July 7th, 1849

7-AGE. 74 yrs. 8 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Louis Lohrfink

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Anna Lutman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-

(Informant) J. Howard Lohrfink

(Address) 3410 Grantley Road.

15-

MAR 23 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit CLERK.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 22nd, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mch 30, 1921, to Mch 22, 19 24

that I last saw him alive on Mch 21, 19 24

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Enlarged right heart
Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

Mch 23 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar 24th, 1924
20-UNDERTAKER. Tolson & Bose	ADDRESS 172 N. Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85121 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85121

1-PLACE OF DEATH

City of BALTIMORE: (No. N. Point & Penna R.R. No. Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Catherine Weber

(a) Residence No... N. Point Rd & Penna R.R. Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married~~ ~~Widowed~~ or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 21/60

7-AGE. 63 yrs. 6 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, Geo. Sauer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Barbara —

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) Louis Sauer

(Address) N. Point Rd. & Penna R.R.

15- MAR 23 1924 ROBERT R. KRAUTER, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/20/24

I HEREBY CERTIFY, That I attended deceased from March 20 1924 to March 20 1924

that I last saw h[illegible] alive on March 20 1924

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) X yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease

(Duration) 1 yrs. X mos. X ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jas. L. Emmons M. D

Mch 21 1924 Address 248 So 3d St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn

DATE OF BURIAL. 3/24 1924

20-UNDERTAKER. Philip Herwig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85122

CERTIFICATE OF DEATH.

D 85122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2416 N Charles ST.; 17 WARD) REGISTERED NO. C 70

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine F. Meagher.

(Residence in Baltimore: No. 2416 N 6 harles St Lukes yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, May 1, 1907
(Month) (Day) (Year)

7-AGE, 17 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Home

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER George R Meagher

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Frances J Blair

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances G. Meagher

(Address) 2416 N. Charles Street

15-

ROBERT R. KRAUTER,

Filed MAR 7 1914, 191.. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21, 1914.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 E 1914, to March 21 1914, that I saw her alive on March 21 1914, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Encephalitis (non Epidemic)

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Paralysis of respiration

(Duration) yrs. mos. 1 ds.

(Signed) Frank M Grume M. D.

March 21, 1914 (Address) 2430 Maryland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lorraine Cemetery DATE OF BURIAL, March 24, 1914

20-UNDERTAKER William Cook ADDRESS 502 E Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85123

CERTIFICATE OF DEATH.

1 29 D 85123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 McDonough ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Owens

(a) RESIDENCE NO. 824 McDonough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Horsey

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Sarah Martin

(Address) 824 McDonough

15 Filed MAR 23 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 7, 1923, to Mar 20, 1924, that I last saw h alive on Mar 19, 1924, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Dis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns, M. D.

3-24-24 (Address) 2017 E. 33

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry cemetery	24 March 1924
20 UNDERTAKER	ADDRESS 1631
Edward Bryan	Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85124 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85124

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 243 S. Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Deckman

(a) Residence No. 243 S. Robinson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Deckman

6-DATE OF BIRTH (month, day and year) Dec. 1. 1857

7-AGE, 67 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), English

PARENTS.

10-NAME OF FATHER, Patrick Duggan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Julia Callahan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Julia Zentkoff

(Address) 712 Lammont Ave

15- MAR 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1. 1924 to Mar. 21., 1924

that I last saw h. alive on Mar. 21., 1924

and that death occurred, on the date stated above, at 8.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Insuff

disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

3-23-1924 (Address) 120 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL, March 24, 1924

20-UNDERTAKER, William G. Schaefer — ADDRESS 1116 Monument

R. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85125

CERTIFICATE OF DEATH.

D 85125

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1005 E. Pratt St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa J. Cummings

(a) Residence No. 1005 E. Pratt St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Mar

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 14 1875

7-AGE	If LESS than 1 day
48 yrs. 7 mos. 7 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Yochim

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, not given

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Thomas Cummings

(Address) 1005 E. Pratt

15- MAR 23 1924 ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 21 24

17- I HEREBY CERTIFY, That I attended deceased from March 1 19 24 to March 20 19 24

that I last saw h[illegible] alive on March 20 19 24

and that death occurred, on the date stated above, at 8 10 m.

The CAUSE OF DEATH* was as follows:

hypo cerebis.

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) influenza pneumonia

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Mahnert M. D.

3/24 19 24 (Address) 14 W. Hoffman

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Holy Cross Cem. Annex	3/24 19 24
20-UNDERTAKER.	**ADDRESS**
Fred G. Krause & Son	703 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Swiecko

D 85126

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 129 ✓

REGISTERED NO. D 85126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Local Hosp. WARD 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Benj Swiecki

(a) RESIDENCE NO. 1 Cypress St. Curtis. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. A. Swiecko

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
About	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Benj. Swiecko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Anastatia Swiecko

(Address) 1 Cypress Curtis Bello

15 Filed MAR 23 1924 19

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21 1924

17

I HEREBY CERTIFY, That I attended deceased from 3-18, 1924, to 3-21, 1924

that I last saw him alive on 3-21, 1924

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

Uremia.

?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia - Cardiac failure. (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) John Tompkins, M. D.

, 19 (Address) Md Local Hosp. & Caste

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Allen	3/25 1924
20 UNDERTAKER J. Fialkowski R	ADDRESS 478 E Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85127

CERTIFICATE OF DEATH.

100-001 ✓

D 85127

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 N. Calvert ST., 11 WARD)

2-FULL NAME Mary F. X. Daly

(a) RESIDENCE No. 926 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Martin Daly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Daly

(Address) 926 N Calvert St

Filed MAR 23 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1924, to Mar 21, 1924.

that I last saw h.r alive on Mar. 21, 1924.

And that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. 2 mos 11 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 926 N. Calvert St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edward C. Smith M. D.

1924 (Address) 16 E Chestnut St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	3/23/24

20 UNDERTAKER ADDRESS

A C Windfelder 917 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stowman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35128

CERTIFICATE OF DEATH.

99-002 ✓

99 D 35128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Lakin ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward D Stowman

(a) RESIDENCE NO. 1502 Lakin ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Stowman

6 DATE OF BIRTH (month, day, and year) June 12-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Bailiff

(b) General nature of industry, business, or establishment in which employed (or employer) Tax Dept. 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Stowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Sarah Bonwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant W. E. Stowman (Address) 1502 Lakin Ave

15 Filed MAR 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1924. to March 22. 1924. that I last saw him alive on March 21 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis + asthma

(duration) 51 yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) L. M. Lampesin M. D.

Mar 23 1924 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	3/24/24
20 UNDERTAKER	ADDRESS
Chas. E. Evans & Son	118 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85129 ✓ 162 D 85129

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH Jackson St. Hospital

CITY OF BALTIMORE: (No. ~~Hustead~~ Mat'l Hosp. ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Pelts

(Residence in Baltimore: No. 415 Eastern Ave. St.: ....yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	

6-DATE OF BIRTH, March 20th, 1924.
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Robert Pelts

11-BIRTHPLACE OF FATHER (State or Country), England.

12-MAIDEN NAME OF MOTHER Lillian Pelts

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Robert Pelts

(Address) 415 Eastern Ave.

15- MAR 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 22nd, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 20th 1924, to March 22 1924, that I saw him alive on March 21st 1924, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Convulsions due to Malaria

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Probable cord and born difficult cases.

(Duration) ....yrs. ....mos. ....ds.

(Signed) E A Smith M. D.

3/22, 1924 (Address) 1605 W Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodef Sh. DATE OF BURIAL, 3-23 1924.

20-UNDERTAKER Jack Levi's 1439 E Balto St. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85130

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

85130

1-PLACE OF DEATH Hebrew Hospital 101-0

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

2-FULL NAME Nathan Coleman

(a) RESIDENCE NO. 1609 N. Fulton Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Musician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Rodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1739 E. Balto.

MAR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/21, 1924, to 3/22, 1924, that I last saw h alive on 3/22, 1924, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Circulatory failure due to
Pneumococcal Type IV
Septicemia (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Isidor L. Levy, M. D.
Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Int Carroll	March 23 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1739 E Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

F

D 85131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85131

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Boulward Apartment St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenore McLeod Naylor

(a) Residence No. Boulward Apts St., 17 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 72 yrs. 8 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. G. Naylor

6-DATE OF BIRTH (month, day and year) July-13-1851

7-AGE, 72 yrs. 8 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Wilmington Delaware

PARENTS.

10-NAME OF FATHER Alex. McLeod

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wilmington Delaware

12-MAIDEN NAME OF MOTHER, Anne Mather

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Wilmington Delaware

14- (Informant) Mr. Laurence G. Naylor (Son)

(Address) Catonsville Md.

MAR 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 17th, 1923, to March 22nd, 1924

that I last saw h.. alive on March 21st, 1924

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Multiple Sarcoma

of about 2 years

duration

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Mitral insufficiency with

Cardiac decompensation

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) [illegible], M. D.

, 19 (Address) 1705 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL, March 24th, 1924

20-UNDERTAKER, [illegible] & OWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH

THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCU In plain terms, so that it may be properly classified.
instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

K

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 85132

CERTIFICATE OF DEATH.

34

D. 85132

1-PLACE OF DEATH

City of BALTIMORE: (No. 401 Woodlawn Road St., 27 Ward.)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Carl Willms Jr.

(a) Residence No. 401 Woodlawn Road St., 27 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? 44 yrs. 3 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Dec-11-1879

7-AGE. 44 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Manuf. Ice

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Crude Rock

(c) Name of employer..... Self

9-BIRTHPLACE (city or town)..... Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Willms

11-BIRTHPLACE OF FATHER (city or town) Cologne (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret B. Boehm

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Germany

14- (Informant) Mrs Julia Willms Daughter

(Address) 401 Woodlawn Road

15- MAR 23 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 9, 1923, to Mar 20, 1924, that I last saw h.. alive on Mar 20, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of spine (4 yr)
with paralysis and (4 mo)
tuberculous meningitis (1 hr)

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of spine.

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms & Hx

(Signed) Robt. Barnett, M. D.

, 19 (Address) 4E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL, Mar 24, 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (CHARLES T. MOWEN, Successor)

ADDRESS 108 W. Lexington

A PERMANENT REC... ACTLY. PHYSICIANS ... Exact statement of OCC...

should be carefully supplied. AGE should be stated EXACTLY. If LESS than 1 day, in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85133

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Glose

(a) RESIDENCE NO. Glen Arm ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred P. Glose

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. H.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Wm Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Alma Rothrock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Husband Cook Glen Arm Md

(Address)

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1924. to 3-23 1924.

that I last saw her alive on March 23, 1924.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows: Albus.

Septicemia - Staphylococcus A.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Induced Abortion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical Findings.

(Signed) [signature], M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bethlehem Penna	March 23 1924
20 UNDERTAKER	ADDRESS
E. LeRoy Stiffler	125 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85134

CERTIFICATE OF DEATH.

23 D 85134

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 333 Gwynn Avenue St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Callahan Jr.

(a) Residence No. 333 Gwynn Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6-DATE OF BIRTH (month, day and year) Dec. 24, 1916

7-AGE. 7 yrs. 2 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John B. Callahan

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Dorothy Green

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country). Maryland

14- (Informant) John B. Callahan

(Address) 333 Gwynn Ave.

15- MAR 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 22-24

17- I HEREBY CERTIFY, That I attended deceased from March 15 19 24 to March 22 19 24

that I last saw h[illegible] alive on March 21 19 24

and that death occurred, on the date stated above, at. 6 A. m.

The CAUSE OF DEATH* was as follows:

Lethal Encephalitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Leth. Encephalitis

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) H. A. Kahl M. D.

3/22 19 24 (Address) Bromley Bldg.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery

DATE OF BURIAL. 3/24 19 24

20-UNDERTAKER. Henry W. Mears & Son

ADDRESS 805 N. Calvert St.

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85135

38

D 85135.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1440 - Harford Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Maria C. Constantino

(a) Residence No. 1440 - Harford Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word)
Female	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 7/19/23

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
— yrs. 8 mos. 4 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Child.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER. Frank Constantino

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy.

12-MAIDEN NAME OF MOTHER. Alma Dehl

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant)..... Frank Constantino

(Address)..... 1440 Harford Ave.

15-

Filed MAR 24 1924 19.. HUBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 23, 1924.

17- I HEREBY CERTIFY, That I attended deceased from March 22 1924 to March 23 1924

that I last saw h.er alive on March 23 1924

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas

Meningitis - septic - probably Staphylococcus

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cervical adenitis, + otitis media - 2 weeks

Congenital syphilis + rickets (Duration) mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None - Lumbar puncture refused

(Signed) Lawson Hilkins, M. D

Mar 23, 1924 (Address) 1014 St Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cemetery	March 24, 1924
20-UNDERTAKER.	ADDRESS
Geo. J. Ruth	1735 Harford Ave.

IN CASE DEATH OCCURRED IN A HOSPITAL OR INSTITUTION, WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter in file June 16th 1924 from Henry C Otte MD

D 85136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 707 E. Biddle ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincenzo Lombardo

(a) RESIDENCE NO. 46) E. Biddle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benedetto Lombardo

6 DATE OF BIRTH (month, day, and year) 3/29/1842

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	81	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tutored 145

(b) General nature of industry, business, or establishment in which employed (or employer) Stonecutter

(c) Name of employer Shoemaker

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Andrea Lombardo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosaudo Rosa Costello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

Informant Andrea Joseph Lombardo

(Address) 707 E. Biddle St

15 MAY 2 A 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1924, to Mch 22, 1924, that I last saw him alive on Mch 22, 1924 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis. Interstitial Nephritis & Myocarditis (duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C Otte M. D.

Mch 22 1924 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cath. Cem.	3/24/25
20 UNDERTAKER Geo. J. Ruth 1735	ADDRESS Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85137

CERTIFICATE OF DEATH.

90 D 85137

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3134 Harford ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Mealey

(a) RESIDENCE NO. 3134 Harford ST., WARD 9
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer —

9 BIRTHPLACE (city or town) New Orleans, La.
(State or country)

PARENTS

10 NAME OF FATHER James —

11 BIRTHPLACE OF FATHER (city or town) New Orleans La
(State or country)

12 MAIDEN NAME OF MOTHER — Mealey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant George J. Ehrly
(Address) 3134 Harford ave

15 MAR 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to March 21st, 1924, that I last saw her alive on March 21st, 1924, and that death occurred, on the date stated above, at 9:10 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert L. Kirk M. D.

3/23. 1924. (Address) 3126 Harford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincent Cemetery	March 24/1924
20 UNDERTAKER	ADDRESS
George J. Roth	1735 Harford ave.

Spec.—1-10-21—M&T—1500 Bks.

D 85138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D 85138

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S Eden ST., 3 WARD)

2-FULL NAME Bonnie Santos

(a) RESIDENCE NO. 218 S Eden ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓		8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Santos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Victorina Valdez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Santos
(Address) 218 S Eden

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17

I HEREBY CERTIFY, That I attended deceased from August, 1923, to March 22, 1924,

that I last saw him alive on March 15, 1924,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Non-Hodgkin's Lymphoma grade IV in Scalp (Blue Berry)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) since birth.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. E. Hunter M. D.

3/24/24 19 (Address) 801 N. Eden St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	3/24/24 19
20 UNDERTAKER	ADDRESS
Wendell Wyzulson	E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85139 | 139 | D 85139

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 W. Lanvale ST.: 16 WARD)

2-FULL NAME Livonia Henry

(a) RESIDENCE. NO. 1108 W. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbert J. Henry

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Asbury Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wilbert J. Henry (Address) 1108 W. Lanvale St.

15 Filed MAR 24 1924 ROBERT K. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 29, 1924. to Mar. 20, 1924.

that I last saw h alive on Mar. 19, 1924.

and that death occurred, on the date stated above, at 7:05 9 m.

The CAUSE OF DEATH* was as follows:

Septicaemia about DURN (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hepatic Obstruction of Bile Duct about (duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

3/20/24 (Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	3/24/24
20 UNDERTAKER Samuel H. Hensley	ADDRESS 1 E. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85140

CERTIFICATE OF DEATH.

REGISTERED NO. 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Taylor.

(a) RESIDENCE NO. 511 N. Bethel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem'a

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Taylor Married.

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Waitress 070

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Hook Williams

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Josephine White

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Frank Taylor (Address) 511 N. Bethel St.

15 Filed MAR 24 1924 17 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/24

17 I HEREBY CERTIFY, That I attended deceased from 3/12/24 19.... to 3/22/24 19.... that I last saw h alive on 3/22/24 19.... and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Hemorrhage

Ovarian Cyst (Ruptured).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? Yes Date of 3/18/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical autopsy

(Signed) K. W. Bolton, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Royal Oak Md	3/25/24
20 UNDERTAKER Thomas F. Kearney & Bro.	ADDRESS 715 N. Bradford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 85141

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 85141

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. First Ave & 16th ST., 26 WARD)

2-FULL NAME Frank Ludwig.

(a) RESIDENCE No. 2nd Ave & 22nd St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Ludwig

6 DATE OF BIRTH (month, day, and year) May 18-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grave-digger
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer St Pauls Cemetery

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wolfgang Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert Eybs (Address) 3004 Dillon St

15 MAR 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Heart Insuf

(Duration) 1 yrs. ... mos. 1 ds.

Chas Ston

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. 1 ds.

(Signed) Geo Clinton Bladg, M. D.

(Coroner)

3/25/24, 192 (Address) 145 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Saint Pauls Cem	March 25 1924
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Deusen.

D 85142

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85142

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1049 N. Caroline ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine Deusen

(a) RESIDENCE No. 1049 N. Caroline ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Deusen

6 DATE OF BIRTH (month, day, and year) Feb 18 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Simon Esser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Rick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. F. F. Schneider

(Address) 1049 N. Caroline St

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to March 22, 1924, that I last saw her alive on March 22, 1924, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemic Poisoning

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) George C. E. Vogler M. D.

March 1924 (Address) 1004 Hartford Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL March 25 1924

20 UNDERTAKER H. Sander Sons — ADDRESS 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-21-E.B.P.S.-400 Blks.

D 85143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85143

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 E. Balto St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta J. Amelang

(a) Residence No. 1600 E. Balto St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 17, 1849

7-AGE. 75 yrs. 1 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Mrs. Winterling

9-BIRTHPLACE (city or town) (State or Country): New York

PARENTS.

10-NAME OF FATHER: August Amelang

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Sophie Reich

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant) Gertrude Amelang

(Address) 1600 E. Balto St.

15-MAR 24 1924 ROBERT R. KRAUTER, Social Service Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 22 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1924 to Mar 22nd 1924

that I last saw h[illegible] alive on Mar 21st 1924

and that death occurred, on the date stated above, at 1.30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhoea

(unknown Origin)

same (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A T Rice, M. D.

Mch. 22 1924 (Address) 24 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem.	March 24 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	170 Park St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85144

CERTIFICATE OF DEATH.

10 1-00 D 85144

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 525 N. Luzerne Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt F. Boyer

(a) RESIDENCE. No. 525 N. Luzerne Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Stetson Iron

(c) Name of employer Foundery

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James F. Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. James Boyer
(Address) 525 N. Luzerne Ave.

15 Filed MAR 24 1924 19 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to March 22, 1924, that I last saw him alive on March 21, 1924, and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Green, M. D.

3/23/24 (Address) 408 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	Mar. 26 1924
20 UNDERTAKER	ADDRESS
H. Sunday & Sons	1210 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85145

CERTIFICATE OF DEATH.

3 / D 85145

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 127 w Hill St., 72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martin Logan

(a) Residence No. 127 w Hill St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. Logan

6-DATE OF BIRTH (month, day and year) 1892

7-AGE, 31 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) D.C.
(State or Country),

PARENTS.

10-NAME OF FATHER, Louis Grady

11-BIRTHPLACE OF FATHER (city or town) Del.
(State or Country),

12-MAIDEN NAME OF MOTHER, Eliza Grady

13-BIRTHPLACE OF MOTHER (city or town) Del.
(State or Country),

14- (Informant) Jas Logan

(Address) 127 w Hill

15- Dec 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 15, 19 24, to Mar 24, 19 24, that I last saw h[illegible] alive on Mar 24, 19 24, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) ? yrs. ? mos. ? ds. about 2 mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? e

Did an operation precede death? No Date of e

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Hamer, M. D.

Mch 24, 19 24 (Address) 1401 Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Washington D.C. DATE OF BURIAL. Mch 24 1924

20-UNDERTAKER John H Toadvine ADDRESS 142 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pds.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85146

CERTIFICATE OF DEATH.

3 1 ✓ D 85146

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lewis

(a) Residence No. 505 S. Spring st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Lewis

6-DATE OF BIRTH (month, day and year) 1893

7-AGE.	If LESS than 1 day.
31 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Unknown

(c) Name of employer. Unknown

0 40

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Spencer Lewis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Susan Taylor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant). Hospital Records

(Address). M.T.H.

15- MAR 24 1924 192 ROBERT A. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 3 1924 to March 21 1924

that I last saw him alive on March 21 1924

and that death occurred, on the date stated above, at 4.15 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L.A. Lally M. D

3-21-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Wenn's Wh Montebello	Mch 24 29
20-UNDERTAKER, John N Toadvine	ADDRESS 142 Argyle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

85147

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
D 85147

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway + Fairmount Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Amelia Lightfoot Locke

(a) RESIDENCE NO. Church Home + Infirmary WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Dr Leonard Locke

6 DATE OF BIRTH (month, day, and year) Oct 9, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Columbus Miss

PARENTS

10 NAME OF FATHER William B. Lightfoot

11 BIRTHPLACE OF FATHER (city or town) (State or country) Port Royal Virginia

12 MAIDEN NAME OF MOTHER Sarah Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mobile Alabama

14 Informant Lora E. L. Reynolds

(Address) 116 W. Hanover St.

FILED MAR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

1 pm

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1924, to March 22, 1924.

that I last saw her alive on March 22, 1924,

and that death occurred, on the date stated above, at 1.15 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Caychan Canettus, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 25 1924

20 UNDERTAKER ADDRESS

John B. Spence, 1325 N. Caroline St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

85148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 ~~0~~ 85148

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... St., 4 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry D. Cook

(a) RESIDENCE No. 314 Diamond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE: Years 54 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Huckster

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital

MAR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1924 to Mar 21, 1924

that I last saw him alive on Mar 20, 1924

and that death occurred, on the date stated above, at 8-20 p.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (Syphilis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith M. D.

3/31/1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 3-24 1924

20 UNDERTAKER: Dan'l Easton — ADDRESS 916 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 16-2-15—H. P. Co.—1000 Bks.

D 85149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 85149

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 749 Wilmot ST.: 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence Buck

(a) RESIDENCE. No. 749 Wilmot ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Buck.

6 DATE OF BIRTH (month, day, and year) Aug 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shindre

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Annie Buck

(Address) 749 Wilmot

MAR 24 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1924, to Mar 21, 1924.

that I last saw h[illegible]live on Mar 21, 1924.

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) H. E. Smith M. D.

Mar 22 (Address) 1 North Bk St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-24 1924
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Eg ave

D 85150

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85150

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 22 Ward) 1886-003

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Osburn Seymour

(Residence in Baltimore: No. 24 Redding Court St. (If less than 1 day, yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1838 (Year)

7-AGE. 71 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Dill Knox

11-BIRTHPLACE OF FATHER. (State or Country) Knox

12-MAIDEN NAME OF MOTHER. Dill Knox

13-BIRTHPLACE OF MOTHER. (State or Country) Knox

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm O Brooks

(Address) 1402 Ward St

MAR 24 1924 192.... ROBERT R. KRAMER Registrar.

MAR 24 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 18 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Shock by cuts & bruises

(Duration) ....yrs. ....mos. 3 ds.

(Signed) H. K. Tyson M. D. (Coroner)

3-24 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	3-24 1924
20-UNDERTAKER. David Earlon	ADDRESS 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85151

CERTIFICATE OF DEATH.

74-901 B 85151

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

B 85151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Ellamont ST. 16 WARD)

2-FULL NAME Barbara Anne Huson

(a) RESIDENCE. NO. 1611 Ellamont ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? 71 yrs 7 mos. 21 ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel S. Huson

6 DATE OF BIRTH (month, day, and year) July 2nd 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	71	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Cromford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. Frank Huson

(Address) # 1611 E Lamont St

15 MAR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23rd 1924

17 I HEREBY CERTIFY, That I attended deceased from March 16th, 1924, to March 23, 1924, that I last saw her alive on March 22nd, 1924, and that death occurred, on the date stated above, at 4.20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - on 16 March paralyzing the right side, and causing loss of speech

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility of age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) John J Pennington, M. D.

, 19 (Address) 1826 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Benjamin Cem. West - Wynnewood Rd	March 25 1924
20 UNDERTAKER	ADDRESS
Wilbur W. Shriver	1018 Edmondson Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85152

D 85152

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Patterson Park Ave. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Haley.

(a) RESIDENCE NO. 1735 Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Sept 10th 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Hemingway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cont. Mass.

12 MAIDEN NAME OF MOTHER Deborah Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cont. Mass.

14 Informant George Haley.

(Address) 1735 Patterson Park Ave

15 Filed MAR 24 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1924, to March 22, 1924

that I last saw h[illegible] alive on March 22, 1924

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral - Hemorrhage

(duration) yrs. 1 mos 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) John B. Owens, M. D.

(Address) 35 S. Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mansakin Md. B. & C. Co. DATE OF BURIAL March 24th 1924

20 UNDERTAKER Leo G. Cook ADDRESS Mathes Haglers Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85153

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85153

CERTIFICATE OF DEATH.

REGISTERED NO. 71-006

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 20 WARD)

2-FULL NAME ~~Dorthy~~ Dorothy A. Shipley

(a) RESIDENCE NO. 505 Jayne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 11/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Lawrence N. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Amelia Fink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City Md.

14 Informant Lawrence N. Shipley
(Address) 505 Jayne Ave

15 Filed ....., 192 ROBERT R. KRAMER, Social Service Chief Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonoccus Meningitis

(No Autopsy)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Falcon, M. D.
(Coroner)

Mar 22/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Mar. 25 192 4

20 UNDERTAKER George L. Schwab

ADDRESS 401 Fulk. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

1700 29 D 85154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85154

+ 60-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 7 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Muha

(a) RESIDENCE NO. 137 Robb St ST., WARD

(Usual place of abode) Johnstown. Pa

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Muha

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER John Muha

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Myrok

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 24 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1924, to Mar. 22, 1924, that I last saw him alive on Mar 22, 19, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease Hyperthyroidism.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3/21/24

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Examination

(Signed) F. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa — DATE OF BURIAL 3/23/24

UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85155

CERTIFICATE OF DEATH.

90 D 85155

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Lamont Ave ST., 9 WARD)

2-FULL NAME Martha P Hales

(a) RESIDENCE NO. 1601 Lamont Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Hales

6 DATE OF BIRTH (month, day, and year) Nov 18/1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Daniel Ford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Somerset Co. Md.

12 MAIDEN NAME OF MOTHER Hester Sommers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Somerset Co. Md.

14 Informant Joseph R. Hales
(Address) 1601 Lamont Ave

15 Filed MAR 24 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Wolman, M. D.
(Coroner.)

Mar 23/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL March 24 1924

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—R.B.P.S.—400 Bks.

B 85156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89

B 85156

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3414 Hurall Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer E. Hurall

(a) Residence No. 3414 Hurall Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Hurall

6-DATE OF BIRTH (month, day and year) July 12-1862

7-AGE,	If LESS than 1 day,
62 yrs. 8 mos. 10 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Paper Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER, Richard Miles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary French

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Anna E. Hurall

(Address) 3414 Hurall Ave

15- MAR 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar-22-24

17- I HEREBY CERTIFY, That I attended deceased from Mar-16- 1924 to Mar-22- 1924

that I last saw him alive on Mar 22 1924

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris from

myocardial degeneration

and cardio arterio sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Heart failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Coley M. D

3/23. 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Lorraine Cemetery	March 24 1924
20-UNDERTAKER	ADDRESS
W. E. Pickney & Son	Balto Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85157

CERTIFICATE OF DEATH.

49 D 85157

1-PLACE OF DEATH City of BALTIMORE: (No. St. Agnes Hospital St., 27 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavinia R Canter

(a) Residence No. 810 Beaumont Ave St., Govans Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE About 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md (State or Country)

PARENTS.

10-NAME OF FATHER, Levin Canter

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md.

12-MAIDEN NAME OF MOTHER, Rebecca Stephens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

11- (Informant) Harry Canter

(Address) 810 Beaumont Ave

15- Final. 3 1924 ROBERT R. KRAMER, City Registrar.

MAR 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/23-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 31 1924 to 3/23 1924

that I last saw h alive on 3/23 1924

and that death occurred, on the date stated above, at 9½ a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bronchial Cleft

Recurrent after operation

(Duration) 2(?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of (?) Mercy Hosp.

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H. Harper, M. D.

, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Mar 25 1924
20-UNDERTAKER.	ADDRESS.
Wm Tucker & Sons	North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85158 + 129 D 85158

CERTIFICATE OF DEATH.

D 85158

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa C. McPherson

(a) RESIDENCE NO. Brooklyn 1 7 2 ST., WARD Non Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. McPherson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79 about.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Worley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Geo. McPherson (Address) 1722 E. Md.

15 Filed MAR 24 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1924, to March 23, 1924, that I last saw h[illegible] alive on March 23, 1924, and that death occurred, on the date stated above, at 7.15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis, Chronic hypertension, Arteriosclerosis, Cardiac hypertrophy, Acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings.

(Signed) Wm. Howard Hays, M. D.

, 19 (Address) 1111 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 25-24
20 UNDERTAKER	ADDRESS
Wm Tucker Sons	North & Fa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85159

CERTIFICATE OF DEATH.

1299 85159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Cedardale Road ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hamilton Walker.

(a) RESIDENCE. NO. 3510 Cedardale Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucretia Osborne Walker

6 DATE OF BIRTH (month, day, and year) May 9. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10	13	

8 OCCUPATION OF DECEASED.

(a) Trade, profession or particular kind of work Accountant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER John Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co. Md.

12 MAIDEN NAME OF MOTHER Sarah A. Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md.

14 Informant Summerfield L. Walker (Address) 3405 Gformley Road.

15 Filed . 19 .

MAR 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to March 22, 1924, that I last saw him alive on March 22, 1924, and that death occurred, on the date stated above, at 5.18 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) Charles Luther Werner, M. D.

, 19 (Address) 3704 Dorchester Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar. 25 1924
20 UNDERTAKER	ADDRESS
Wm Tuckerdons	North Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 74-001

D 85160

1-PLACE OF DEATH

City of BALTIMORE: (No. 2522 Maryland Ave. St., 12 Ward)

Registered No. D 85160

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernice Leigh Willing

(Residence in Baltimore: No. 2522 Maryland Ave. St.; yrs., 20 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. June (Month) 12 (Day) 1871 (Year)

7-AGE. 52 yrs. 9 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sea Captain
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). -Irvington Va.

PARENTS.

10-NAME OF FATHER. Thomas J. Willing

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Sarah Messick

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret E. Willing

(Address) 2522 Maryland Ave.

15- Filed MAR 24 1924 ROBERT R. KRAUTER Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 9 (Day) 192.4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D. (Coroner.)

Mar 22 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	March 24 1924
20-UNDERTAKER.	ADDRESS
Wm. J. Tickner & Sons	North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85161

CERTIFICATE OF DEATH.

9-1-007 D 85161

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Walbrook Ave ST.: 15 WARD)

2-FULL NAME Annie E. Bailey

(a) RESIDENCE. No. 2912 Walbrook Ave WARD.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs mos. ds. How long in U. S., if of foreign birth? Life. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Edward Bailey

6 DATE OF BIRTH (month, day, and year): Apr. 3 1871

7 AGE: Years 52 Months 11 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Queen Anne Co. Maryland

PARENTS

10 NAME OF FATHER: Thomas Edenfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Annie Hawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Edward Bailey 2912 Walbrook Ave

15 Filed MAR 24 1924, 19.....

ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Mar 22, 1924, that I last saw her alive on Mar 22, 1924, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with Hypertension.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Sidney H. Stigett M. D.

3/23 1924 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Queenstown Md — DATE OF BURIAL: Mar 24 1924

20 UNDERTAKER: Wm J. Richardson — ADDRESS: Northeast Pa

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85162

CERTIFICATE OF DEATH.

7 74 901 ✓ D 85162

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1034 N. Broadway St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Rosenblatt

(a) Residence No. 1034 N. Broadway St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? 22 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 49 yrs. — mos. — ds. If LESS than 1 day, hrs. or.... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer) 080
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Sonnel Rosenblatt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Mollie Rosenblatt
(Address) 1034 N. Broadway

15- Filed MAR 24 1924 192 ROBERT P. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 23/24

17- I HEREBY CERTIFY, That I attended deceased from 2/21 19 24 to 3/2 19 24
that I last saw h[illegible] alive on 3/2 19 24
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) yrs. 0 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.
3/25 1924 (Address) 826 E. Oaks St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rising Sun — DATE OF BURIAL, 3/24 1924

20-UNDERTAKER, [illegible] Levinson & Bro — ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85163

CERTIFICATE OF DEATH.

47 D 85163

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lawrence & Lemmon ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Butler

(a) RESIDENCE NO. 836 Pleasant Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Benjamin Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Mary ??

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Hospital Records

(Address)

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-10 .1924. to 3-21 .1924.

that I last saw her alive on 3-21 .1924.

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pagets disease of left breast.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-11-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. H. Miller M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	March 24 1924
20 UNDERTAKER	ADDRESS
Chas T Brown & Son	1501 Mont

Spec.—1-10-21—M&T—1500 Bks.

D 85164

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85164

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Henry

(a) RESIDENCE NO. 43 Russell St W Mynans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Henry.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas F. Branch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma Young.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 22, 1924,

that I last saw h alive on March 22, 1924,

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia contracted — pulmonary tuberculosis

Uraemia — Lymphosarcoma of Cervical Lymph Glands, Abdominal Metastasis. Cardiac decompensation (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	March 26 1924
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85165

CERTIFICATE OF DEATH.

90 D 85165

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 W. 38th St. 13 WARD)

2-FULL NAME Oscar M. White

(a) RESIDENCE NO. 917 W. 38 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Rena White

6 DATE OF BIRTH (month, day, and year) Mar 25-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoffer Ofc

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Talbert White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emma McConnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Rena White

(Address) 917 W 38 St St

15 Filed ..... 19 ..... Registrar

MAR 24 1924 ROBERT N. WILSON Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1923, to Mar 22 1924, that I last saw him alive on Mar 22, 1924 and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

R. Hemiplegia

(duration) yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Embolus from heart

disease (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Rawants M. D.

3/24 1924 (Address) 866 W. 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys

DATE OF BURIAL Mar 25 1924

20 UNDERTAKER D. S. Marshall

ADDRESS 3339 Fall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 85166

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 85 D 85166

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Homewood Ave ST., 12 WARD)

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William G. Ulrich Jr

(a) RESIDENCE NO. 2008 Homewood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Aug 18/1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. H. Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Leona Warnsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Wm. H. Ulrich
(Address): 2008 Homewood Ave

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Accidentally fell down stairs while carrying pail of boiling water, on Feb 23 scalding rt. hip & leg.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Watts, M. D.
(Coroner.)

Mar 23/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: March 27/24

20 UNDERTAKER: John Leeris — ADDRESS: 208 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85167

101-001

D 85167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 115 N Monteford ave 6 Registered No.....

City of BALTIMORE: (No. 115 N. Montford St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Alice E. Sullivan .....

(a) Residence No. 115 N Montford St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robt W Sullivan

6-DATE OF BIRTH (month, day and year) Aug 23/1885

7-AGE. 38 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... At home
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 37
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Stevenson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Kentucky

12-MAIDEN NAME OF MOTHER, Mary Barlow

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Balto

14-(Informant) Robt W. Sullivan

(Address) 115 N Montford Ave

15-Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar. ~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 22/1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 11, 1924 to Mar 22, 1924

that I last saw h[er] alive on Mar 22, 1924

and that death occurred, on the date stated above, at 6 55 P. M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(Duration) yrs. mos. 11 ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Macdonald M. D.

Mar 23 1924 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Olivet	Mar 25, 1924
20-UNDERTAKER. John Elliott	ADDRESS 2008 Elson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85168

CERTIFICATE OF DEATH.

3/ D 85168

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Sexton ST. 25 WARD)

2-FULL NAME Thomas Mason

(a) RESIDENCE NO. 1009 Sexton ST., Jermell Park WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Entire yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Mason

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: 56 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Dairyman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Mary E. Mason

(Address) 1009 Sexton St

15 MAR 24 1924 ROBERT P. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21 1924

17

I HEREBY CERTIFY, That I attended deceased from 3-17-, 1924, to 3-21-24, 19...,

that I last saw him alive on 3-21-24, 19...,

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

3/22 1924 (Signed) W. B. Hall, M. D.

(Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: March 26 1924

20 UNDERTAKER: Jos B Cook — ADDRESS: 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21 - E.B.R.S.—400 Blks.

D 85169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85169

CERTIFICATE OF DEATH.

15 91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2727 W. North ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Summerfield Vinton Baker

(a) Residence No. 2727 W. North Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, ~~Widowed~~, or Divorced. (Write the word)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Baker

6-DATE OF BIRTH (month, day and year) April 13 1859

7-AGE.	If LESS than 1 day.
64 yrs. 11 mos. 10 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Heidelen Co 066

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Aberdeen Harford Co Maryland

PARENTS.

10-NAME OF FATHER. John H. Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Harford Co. Maryland

12-MAIDEN NAME OF MOTHER. Sarah Ruff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Harford Co. Maryland

11- (Informant) Mrs. Matilda Baker

(Address) 2727 W. North Ave.

MAR 24 1924 ROBERT R. KRAMER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23 1924

17- I HEREBY CERTIFY, That I attended deceased from June 5a 1923 to March 23 1924, that I last saw him alive on March 23 1924, and that death occurred, on the date stated above, at 2 40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 1 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lamard E Beach M. D.

, 19 (Address) 2231 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet	Mch 25, 1924
20-UNDERTAKER	ADDRESS
Jos B Cook	1503 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85170

CERTIFICATE OF DEATH.

X74-001 ✓

Registered No. C. 1170 D 85170

1-PLACE OF DEATH on 3rd st Mt Royal Sta.

City of BALTIMORE: (No. ~~—~~ R. R. Train Near Balto St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Joseph Jr~~ Henry Salmon

(Residence in Baltimore: No. Catonsville Md St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

6-DATE OF BIRTH. June (Month) 15 (Day) 1850 (Year)

7-AGE. 73 yrs. 7 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Baggageman
(b) General nature of industry, business, or establishment in which employed (or employer) on B & O R.R.

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Anthony Salmon

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Helena C. Salmon

(Address) Catonsville Md

15-

Filed MAR 24 1924 192.. ROBERT R. KRAUTER (1) Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 22 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy or Inquiry.~~ thereon and from the evidence obtained by said ~~Inquest, autopsy or Inquiry.~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

about hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) W. S. Forrest M. D.
(Coroner.)

3-24 192 3 (Address) 43 N. Paca St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount

DATE OF BURIAL. Mch 26 1924

20-UNDERTAKER. Lee B Cook

ADDRESS 1003 E Balto St

Spec—12-23-21—E.B.P.S.—400 Bks.

D 85171

HEALTH DEPARTMENT—CITY OF BALTIMORE

179

D 85171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 N. Monroe St. 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lisette Stuehrl

(a) Residence No. 520 N. Monroe St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of G. Wm. Stuehrl

6-DATE OF BIRTH (month, day and year) Sept 16, 1861

7-AGE. 62 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Duties

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. August Sturlbrink

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Eliz. Nordhof.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) G. Wm. Stuehrl

(Address) 520 N. Monroe

15-

Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

MAR 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 22/24

I HEREBY CERTIFY, That I attended deceased from Feb. 27 1924, to Mar. 22 1924,

that I last saw her alive on Mar. 22 1924,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis, Cerebral Arterio Sclerosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemic Convulsions

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) K. C. Krieth M. D.

Mar. 23, 1924 (Address) 1903 W. North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Mar 26, 1924

20-UNDERTAKER. Mrs. Nus John W. Leufelvson — ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85172

CERTIFICATE OF DEATH.

1/3 D 85172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 18 S Register ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theo Tibite

(a) RESIDENCE NO. 18 S Register ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/c yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence White

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Cooper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Clarence White
(Address) 155 Pearson St

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pastor Embolism

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

(Signed) Geo Claiborne Wades, M. D.

(Coroner) March 23 1924 (Address) 1423 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 3-28-24

20 UNDERTAKER Theo W. White

ADDRESS S Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-12-23-21—E.B.R.S.—400 Bks.

D 85173

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85173

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 503 S. Linwood ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Gordon Edward Stotsky

(a) Residence No. 503 S. Linwood ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan. 29-1922

7-AGE. 2 yrs. 1 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Andrew Stotsky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Alice Dannenfelser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) Alice Stotsky

(Address) 503 S. Linwood ave

15- Filed MAR 24 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21-24

17- I HEREBY CERTIFY, That I attended deceased from 3/17, 19 24, to 3/21, 19 24

that I last saw him alive on 3/21 19 24

and that death occurred, on the date stated above, at 3.15 am m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, left lower lobe.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mucous Colitis.

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C A Reifschneider, M. D.

3/24, 1924 (Address) 2939 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	March 24, 19 24
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85174

CERTIFICATE OF DEATH.

31 D 85174

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 935 S. Linwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Hetzner

(a) Residence No. 935 S. Linwood Ave St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~ or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Barbara Hetzner

6-DATE OF BIRTH (month, day and year) July 31, 1860

7-AGE. 63 yrs. 7 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Lumber

(c) Name of employer. Canton Lumber Co

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Mary Conrad

(Address) 935 S. Linwood Ave

15- MAR 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to March 22, 1924

that I last saw h. ~~im~~ alive on March 21, 1924

and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) M. D.

3/22, 1924 (Address) 864 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Carmel Cemetery	March 25 1924
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85175

CERTIFICATE OF DEATH.

D 85175

1-PLACE OF DEATH

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 212 N. Luzerne ave ST., 6 WARD)

2-FULL NAME Ida M. Smith

(a) RESIDENCE No. 212 N. Luzerne ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin H. Smith

6 DATE OF BIRTH (month, day, and year) May 7, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Sheridan H. Smith
(Address) 212 N. Luzerne

15 Filed MAR 24 1924 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to March 22, 1924, that I last saw h alive on March 22, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of the left breast

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. B. Fuge, M. D.

, 19 (Address) 836 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 3/26 19 24

20 UNDERTAKER Fuller & Fuller — ADDRESS 739 Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—2-15-24—M&T—700 Bks.

D 85176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 179 D 85176

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie B. Ritter

(a) RESIDENCE NO. 1774 E.North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert F. Ritter

6 DATE OF BIRTH (month, day, and year) May 26/1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) 037 (
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo. A. Frederick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Addie B.Lovett

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Robt. F. Ritter
(Address) 1774 E.North ave

15 Filed ... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia - Acute Nephritis
Due to burns over body- Clothing caught fire from coal stove. Mar 14/24
Accidental) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Mace, M. D.
(Coroner.)

Mar 22 24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Mar 25 192
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35177

CERTIFICATE OF DEATH.

10 D 35177

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 329 S. Gilmore St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Edward W. Moore

(a) Residence No. 329 S. Gilmore St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 5/22

7-AGE. X. 1 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None fld

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country).

PARENTS.

10-NAME OF FATHER Martin W Moore

11-BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or Country)

12-MAIDEN NAME OF MOTHER Margaret M Kenny

13-BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or Country)

14-

(Informant) Margaret M. Moore

(Address) 329 S. Gilmore St

15-

Filed MAR 24 1924 ROBERT R. KRAUTER,

192.....

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23/24

17- I HEREBY CERTIFY, That I attended deceased from March 17 1924, to Mar 23 1924

that I last saw h. alive on Mar 23 1924

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Diphtheria.

(Duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary) General Toxemia

(Duration) 0 yrs. 0 mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? — Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) John L. Stansbury M. D.

Mar 23 1924 (Address) 1037 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baby Rose Harford Mar 25 1924

DATE OF BURIAL.

20-UNDERTAKER. Williamson & Son

ADDRESS E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85178

D 85178

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 Pressident St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Trockenbrot

(a) Residence No. 307 Pressident St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed or Divorced~~ (Write the word.) Married

5a-If married, ~~widowed or divorced~~ (HUSBAND of ~~no~~) WIFE of Edward Trockenbrot

6-DATE OF BIRTH (month, day and year) July 28-1881

7-AGE. 42 yrs. 7 mos. 23 ds. If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work Cabinet Maker
(b) General nature of Industry, business, or establishment in which employed (or employer) (37)
(c) Name of employer.....

9-BIRTHPLACE (City or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Fredic Stargen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant Edward Trockenbrot

(Address) 307 Pressident

15-Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 22-1924

17-I HEREBY CERTIFY, That I attended deceased from Jan 10 1924 to March 23 1924

that I last saw h.. alive on March 22 1924

and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Anasarca

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lewis M. D.

3/28. 1924 (Address) 413 Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL Mar 25 1924

20-UNDERTAKER, W. M. Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—1-10-21—M&T—1500 Bks.

3 4 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

1 7 0 85179

D 85179

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Ware.

(a) RESIDENCE NO. 317 Diamond St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Femal	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ~~H~~

(c) Name of employer ~~H~~

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha Loveday

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 19, 1924, that I last saw h~~er~~ alive on March 19, 1924, and that death occurred, on the date stated above, at 1.05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) Not known. yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension, uraemia, Asthma, Pulmonary oedema.

(duration) Not known.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) R. W. Te Linde, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 3/25 1924

20 UNDERTAKER Jas. M. Skinner

ADDRESS 1620 E. Mad. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-601 ✓

D 85180

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N Chapel ST., 7 WARD)

2-FULL NAME Norman A Chester

(a) RESIDENCE NO. 1022 N Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (~~write the~~ word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10. 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
~~8~~	8	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NO

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington

12 MAIDEN NAME OF MOTHER Anne Chester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Irene Chester

(Address) 1022 N Chapel St

15 Filed MAR 24 1924, 19..... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 22, 1924.

that I last saw h~~e~~ alive on March 20, 1924,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Leonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm S Gadd, M. D.

3/22, 1924 (Address) 919 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	3/24 1924
20 UNDERTAKER	**ADDRESS**
Jas. M. Skinner & Co.	1100 Mad. st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85181

CERTIFICATE OF DEATH.

'45 D 85181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 56 Mason ST.; Mooresville WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Okros

(Residence in Baltimore: No. 56 Mason St. Mooresville St.; 20 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male.	White	Married

6-DATE OF BIRTH. December 13, 1881.
(Month) (Day) (Year)

7-AGE. 42 yrs. 3 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Metal Cor
(b) General nature of industry, business, or establishment in which employed (or employer)..... Builder

9-BIRTHPLACE, (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Austria

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Theresa Okros

(Address) 56 Mason St.

15- MAR 24 1925

Filed....., 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 21st, 1925.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 3 1925, to Mar. 21 1925, that I saw him alive on Mar. 21 1925 and that death occurred, on the date stated above, at 6 10 p.m.

The CAUSE OF DEATH* was as follows:

a.....

Carcinoma - Intestines

.....

..... (Duration) yrs. 6 mos. ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) H. L. Lurth M. D.

Mar. 24, 1925 (Address) 811 E. Pennsylvania

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
Cedar Hill	Mar. 24, 1925
20-UNDERTAKER	ADDRESS
George L. Schwab	2101 Eutaw Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 85182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 85182

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 South Paca ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Izidor Simanoviz

(a) RESIDENCE NO. 437 South Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 59	Years —	Months —	Days	If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laber

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Peter Simanoviz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Anne Zuratis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Monik Momkevic

(Address) 437 S Paca Street

15 Filed MAR 24 1924 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22. 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to March 22, 1924, that I last saw him alive on March 21, 1924, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) mitral Regurgitation

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical Findings

(Signed) J. a Buchmiss, M. D.

, 19 (Address) 650 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 26. 1924

20 UNDERTAKER ADDRESS

John Grebliauckas J.G. 425 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85183

CERTIFICATE OF DEATH.

44 D 85183

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ross

(a) Residence No. 425 N. Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1871

7-AGE: 53 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O.D.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Ross

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- FILED MAR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-19-24

17- I HEREBY CERTIFY, That I attended deceased from 3-14, 1924, to 3-19, 1924, that I last saw h[illegible] alive on 3-19, 1924, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Bruce M. D.

3-19, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, 3/24/24

20-UNDERTAKER, R. B. Gross — ADDRESS 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85184

CERTIFICATE OF DEATH.

D 85184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lynch.

(a) RESIDENCE NO. Northcliffe Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Lynch.

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 056

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy Man

(c) Name of employer Md.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Lynch

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hanlon

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Record
(Address)

15 Filed MAR 24 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/24

17 I HEREBY CERTIFY, That I attended deceased from 10/20/23, 19..., to 3/24/24, 19..., that I last saw him alive on 3/24/24, 19..., and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma.
Gastric ulcer.

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Autopsy

(Signed) K. W. Hurley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glen Arm	Mar 24 1924
20 UNDERTAKER E. L. Roy Stuffler	ADDRESS 1252 North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1021—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85185

CERTIFICATE OF DEATH.

1601 ✓

D 85185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 N. Fredrick ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Geo. M. Krimm

(a) RESIDENCE No. 214 N. Fredrick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 22/1924

7 AGE Years Months Days

If LESS than 1 day / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Geo. M. Krimm

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Grace V. Wilson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Geo. M. Krimm

(Address) 214 N. Fredrick St.

15 Filed MAR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1924, to Mar 22, 1924

that I last saw h[illegible] alive on Mar 22, 1924

and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 mo. Intra Uterine Retention

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Edematous

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gleaned

(Signed) R. R. Campbell M. D.

Mar 23 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney Hill Cem	March 24 1924
20 UNDERTAKER	ADDRESS
H. Howard Evans	38 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85186

HEALTH DEPARTMENT—CITY OF BALTIMORE

89

D 85186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. 5th St ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara E. Omeis

(a) RESIDENCE NO. 711 S. 5th St. ST., 26 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John S. Omeis

6 DATE OF BIRTH (month, day, and year) Oct. 17 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susanna Baumann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew J. Omeis

(Address) 711 S. 5th St

15 MAR 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1924, to March 22, 1924,

that I last saw her alive on March 22, 1924,

and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Frank A. Glantz, M. D.

Mar 24, 1924 (Address) 32 W. Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL Mar 26 1924

20 UNDERTAKER Harry H. Hancock

ADDRESS 4204 Ridgewood Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85187

CERTIFICATE OF DEATH.

74-001 B 85187

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 N. Milton ave St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary E. Burnitt

(a) Residence No. 705 N. Milton av St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 2/39

7-AGE. 85 yrs. 2 mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired 068

(b) General nature of industry, business, or establishment in which employed (or employer)..... School Teacher

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... City.
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm A. Burnitt

11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Jane Guest

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country),

14- (Informant) James A. Wallace

(Address) 705 N. Milton av

15-

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

MAR 24 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/21/24

17- I HEREBY CERTIFY, That I attended deceased from 3/18/24 19.... to 3/21/24 19....

that I last saw h.. alive on 3/21/24 19....

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Paralysis

apw

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Hardening of Arteries & Blood Pressure

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ..... ft

Did an operation precede death? ..... Date of .....

Was there an autopsy? ..... no

What test confirmed diagnosis? Clinical

(Signed) C. C. Beacon, M. D

3/22, 1924 (Address) 39 W Eager ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Pk.	3/25, 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85188

CERTIFICATE OF DEATH.

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 N. Montford Ave St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Beissler

(a) Residence No. 704 N. Montford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? 65 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced (HUSBAND or) WIFE of Bernard Beissler

6-DATE OF BIRTH (month, day and year) Sept 5 1855

7-AGE. 68 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Austria

PARENTS

10-NAME OF FATHER, Joseph Kaufman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Theresa Huber

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Austria

11- (Informant) Mr. Bernard Beissler

(Address) 704 N. Montford Ave

M- MAR 24 1924 ROBERT N. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23 1924

17- I HEREBY CERTIFY, That I attended deceased from about 1900 to Mar 23 1924

that I last saw he alive on Mar 23 1924

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma Arthritis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? c

Did an operation precede death? no Date of c

Was there an autopsy? no

What test confirmed diagnosis? Picking

(Signed) D. T. Roder M. D.

19 (Address) 1904 E. Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery DATE OF BURIAL. Mar 27 1924

20-UNDERTAKER. Henry Storck Son ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85189

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenta Shopf

(a) RESIDENCE NO. 110 S. Curley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amos Shopf

6 DATE OF BIRTH (month, day, and year) 1885 Oct. 26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	38	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Zimmerer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Winkelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Bay View Hospital

15 Filed ..... 19 ..... ROBERT A. KRAUTER, Registrar

MAR 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1923. to March 23. 1924.

that I last saw her alive on March 22, 1924.

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis.
Luetic Infection
Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneum.
(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic & Serological

(Signed) N. G. Edmunt M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 26, 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85190 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 85190

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH St Paul + 31st St.

CITY OF BALTIMORE—No. Hopkins apt. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William De Courcy May.

(a) RESIDENCE No. Hopkins apts ST., ... WARD .....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or ~~divorced~~ HUSBAND of (or WIFE of): Josephine Izard May

6 DATE OF BIRTH (month, day, and year): 1851-7-27

7 AGE: Years 72 Months 8 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 016

(b) General nature of industry, business, or establishment in which employed (or employer): Ship Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry May

11 BIRTHPLACE OF FATHER (city or town) (State or country): D.C.

12 MAIDEN NAME OF MOTHER: Henriette DeCourcy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Queenstown Co Md.

14 Informant: George May

(Address): Balto & Calvert

15 Filed MAR 24 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/23/1924

17 I HEREBY CERTIFY, That I attended deceased from October, 1923, to March 23d, 1924.

that I last saw him alive on March 21st, 1924.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Tuberculosis of Pulmonary

(duration) 20 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Recurrent Pulmonary Hemorrhage (duration) abt 2 yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? (In Balto: about 10 mos. Came from Cal: here.)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. E. Lecompte M. D.

3/23/1924 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 3-27 1924

20 UNDERTAKER: Henry J Jenkins Sons Co

ADDRESS: McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85191

CERTIFICATE OF DEATH.

100-001

D 85191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1102 E. Monument ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Sherman Kemp Frederick

(a) RESIDENCE No. 1102 E. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colard

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1- 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER James Frederick

11 BIRTHPLACE OF FATHER (city or town) West End
(State or country)

12 MAIDEN NAME OF MOTHER Rosie M Kemp

13 BIRTHPLACE OF MOTHER (city or town) S C
(State or country)

14 Informant James Frederick (Address) 1102 E Monument St

15 MAR 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1924. to March 23. 1924.
that I last saw him alive on March 23. 1924.
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. G. McKammon, M. D.

3-23 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: Mar 24 1924

20 UNDERTAKER: Robert E Wilkins — ADDRESS: 1515 McElderry

Spec– 12-23-21– E.B.R.S.—400 Bks.

D 85192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1011 Woodbourne St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine R. Barnard.

(a) Residence No. 1011 Woodbourne St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Wm. H. Barnard.

6-DATE OF BIRTH (month, day and year): Dec 29 - 1856

7-AGE: 67 yrs. 2 mos. 24 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): N. Y.

PARENTS.

10-NAME OF FATHER: Oscar Dingee

11-BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.

12-MAIDEN NAME OF MOTHER: Patrina B. Roberts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14-(Informant): Wm. H. Barnard

(Address): 1011 Woodbourne

15-
Filed ..... 192.....

ROBERT R. KRANTZ, Burial Permit Clerk.

MAR 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Mch 23, 1924, to Mch 23, 1924,
that I last saw h[illegible] alive on Mch 23, 1924,
and that death occurred, on the date stated above, at 4 45 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

1 hour (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

1 hour (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? At Residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. Duncan M. D

Mch 23, 1924 (Address) 5106 York Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) **whether Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Poughkeepsie N. Y. — DATE OF BURIAL: 3/25 1924

20-UNDERTAKER: J. F. McCully — ADDRESS: 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

B 85193

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

B 85193

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. White Sisters of Our Lady St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Deily

(a) Residence No. Preston & Valley Sts. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~ Married, Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 27 May, 1837

7-AGE, 86 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... ~~fol~~

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Deily

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germ

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germ

14- (Informant)..... Sister Florence

(Address)..... Preston & Valley

15- Filed MAR 24 1924 Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 23 1924

17- I HEREBY CERTIFY, That I attended deceased from to Record, 19....., to....., 19.....

that I last saw him alive on....., 19.24

and that death occurred, on the date stated above, at 4.15 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Coma

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) H A Warner, M. D.

March 13/24 19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Cross — DATE OF BURIAL, Mar 27 1924

20-UNDERTAKER, J. E. Kindsvater — ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 85194

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1437 Webb St ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Turk

(a) RESIDENCE NO. 1437 WebbSt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 12/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	X	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Preston Turk

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Ruth Map

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mary Turk
(Address) 1437 Webbs.

15 Date ..... 192 ..... Registrar

MAR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Gastro-Intestinal Indigestion

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Scott Evans, M. D. (Coroner.)

Mar 24/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 29 1924
20 UNDERTAKER Wm. H. C. Elliott	ADDRESS 1722 Eutaw

NAME IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

85195

90 D 85195

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 Harford Ave ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James E. Banks

(a) RESIDENCE NO. 725 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Banks

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Banks
(Address) 725 Harford Ave

15 MAR 24 1924 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) mar 20/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Valvular Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Patten, M. D.
(Corner.)
Mar 24/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Mar 27 1924
20 UNDERTAKER Geo. R. G. Elliott	ADDRESS 125 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85196

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓

D 85196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Claggett ave ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Hale

(a) RESIDENCE NO. 509 Claggett ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem. | 4 COLOR OR RACE Col. | 5 Single, Married, Widowed, or Divorced, (write the word) Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Joseph Schendollar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co

12 MAIDEN NAME OF MOTHER Susana Schendollar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) born in Howard Co

14 Informant (Address) Chas C Hall 509 Claggett ave

15 MAR 24 1924 ROBERT I. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1924, to March 22, 1924, that I last saw h alive on March 22, 1924, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Howard, M. D.

, 19 (Address) 509 Claggett ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL March 25 1924

20 UNDERTAKER Mrs R A Elliott — ADDRESS 172 S Ashland Av

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85197

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 85197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 823 N Luzerne St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Benesch

(a) Residence No. 823 N Luzerne St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: Single (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 10 1919 Feb 20

7-AGE: 4 yrs. 3 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Ignatius Benesch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Bertha Marschutz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New York

11-Informant (Informant) I. Jackson Benesch

(Address) 823 N Luzerne Av

15-Filed MAR 24 1924 ROBERT A. KNIGHT, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23/24

17-I HEREBY CERTIFY, That I attended deceased from March 1- 1923 to March 23 1924

that I last saw him alive on March 23 1924

and that death occurred, on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Septic endocarditis

following Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ryseck M. D.

(Address) Mar. & Pitcairn Co

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Mar 25 1924

20-UNDERTAKER: Hunt & Evenson — ADDRESS: 1906 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85198

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 W. Lombard ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Murray.

(a) RESIDENCE NO. 1111 W. Lombard ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) May, 24, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	67	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab. 62

(b) General nature of industry, business, or establishment in which employed (or employer) Watchman

(c) Name of employer Davis Tin Co.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Murray.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Annie Murray. (Address) 1111 W. Lombard St

15 Filed MAR 7 A 1924, 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1924.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1924. to March 21. 1924.

that I last saw him alive on March 21, 1924;

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis etc.

(Signed) Thaabornton, M. D.

3/24/24 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL Mar 26 1924

20 UNDERTAKER John B Fields — ADDRESS 1200 W Fayette

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85199

CERTIFICATE OF DEATH.

129 D 85199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1327 Ramsay ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert M. Evans.

(a) RESIDENCE No. 1327 Ramsay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura G. Evans.

6 DATE OF BIRTH (month, day, and year) Oct. 25 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker,

(b) General nature of Industry, business, or establishment in which employed (or employer) Metal Work

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Alex. Evans,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Adelina Keefer,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Laura G. Evans.

(Address) 1327 Ramsay St

15 MAR 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 1924.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1924. to Mar. 22, 1924.

that I last saw him alive on March 22, 1924.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis,

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Alcoholism Chronic

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Micro etc.

(Signed) John Thornton, M. D.

3/24/24 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Mar 26 1924

20 UNDERTAKER John Stull — ADDRESS 1200 W. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85200

CERTIFICATE OF DEATH.

1290 D 85200

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1514 W Lexington ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Louise Staylor

(a) RESIDENCE NO. 1514 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm A. Staylor

6 DATE OF BIRTH (month, day, and year): Jany 3. 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: James Menzies

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Louise M. Cheguine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Wm. R. Staylor

(Address): 413 Frederick Ave

15 Filed ... 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MAR 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 1. 1923. to March 23. 1924.

that I last saw h[illegible] alive on March 23. 1924.

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio-arterial sclerosis 2 yrs chronic interstitial nephritis and arterio sclerosis

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? no Date of —

Was there an autopsy? no — Were findings confirmed by chemical + microscopic

What test confirmed diagnosis?

(Signed) H. V. Arthur M. D.

3/25 1924 (Address) 1476 W Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Mch 25 1924

20 UNDERTAKER: John O Mitchell — ADDRESS: 1201 W. Fayette St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85201

HEALTH DEPARTMENT—CITY OF BALTIMORE

122 D 85201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE (No. 11 N. Calhoun St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Judge Henry Stockbridge

(a) Residence No. 11 N. Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Helen S Stockbridge

6-DATE OF BIRTH (month, day and year) Sept 18 1856

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Judge

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Henry Stockbridge

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mass.

12-MAIDEN NAME OF MOTHER Fannie Montague

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Mass

11- (Informant) Henry Stockbridge 3rd

(Address) Tow Hills

13-

Filed ... 19... Robert P. Harrison, Registrar.

MAR 24 1924

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 22 1924

17- I HEREBY CERTIFY, That I attended deceased from December 8 1923 to March 22 1924

that I last saw him alive on March 22 1924

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver (Not Bladder)

The exact cause not known

(Duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis and Edematous Disease of the Heart

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? The Physical Signs & Symptoms were positive

(Signed) Charles Gelb M. D.

March 25, 1924 (Address) 111 W. Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL.

Loudon Park. March 25 1924

20-UNDERTAKER. — ADDRESS

John O. Mitchell 220 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85202

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85202

CERTIFICATE OF DEATH.

REGISTERED NO. 117-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST., (WARD)

2-FULL NAME Joseph W. Bennauzar

(a) RESIDENCE No. 2933 Belmont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Carrie Cox Bennauzar

6 DATE OF BIRTH (month, day, and year) Oct 23 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	5	=	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) 159

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Jos H. Bennauzar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Ann Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hannah B. Starrette (Address) 16 Lamvale ave

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk

R 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 23, 1924, that I last saw him alive on March 23, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of March 17-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operation

(Signed) Louis Hubert Wiepman, M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Mch 26 1924

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85203

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital ST., Baltimore WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Adaline Root

(a) RESIDENCE NO. 1038 Market ST., WARD Parkersburg, W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 23 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	29	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ulrichsville, Ohio.

PARENTS

10 NAME OF FATHER John Wesley Root

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lena Bisman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs J. W. Root (mother)
(Address) 1038 Market St, Parkersburg W. Va.

15 Filed MAR 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 24, 1924, to March 24, 1924,

that I last saw her alive on March 24, 1924,

and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Sub-acute)

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Pyonephrosis (bilateral)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Parkersburg, W. Va.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination.

(Signed) S. F. Goff M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ravenna Ohio

DATE OF BURIAL Nov. 20 1924

20 UNDERTAKER John A. Mitchell

ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 85204 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Ostend ST. 21 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME not named

(a) RESIDENCE NO. 1216 Ostend ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/21/24

7 AGE Years: 9 months 10 days | Months: — | Days: — | If LESS than 1 day 3 hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Bernard Smith

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mabel Stemmer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant ... (Address) ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1924, to 3-24-, 1924.

that I last saw h— alive on ..., 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

... (duration) yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) —

... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Richard Dorsey M. D.

, 19 (Address) 1216 Ostend

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL ... 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL MAR 24 1924

Dept. Vital Statistics Bureau of Health

Per Wm. E. WOODALL

MAR 24 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85205

CERTIFICATE OF DEATH.

10 003 ✓ D 85205

1-PLACE OF DEATH Mercy Hosp.

CITY OF BALTIMORE: (No. Balt. 2nd ST., 3 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Borowski.

(a) RESIDENCE NO. 834 E. Pratt ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Benfany Borowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Veronica Rodawig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) Hospital Records

15 Robert P. Harrison, ... 19 ..... Registrar
Burial Permit Clerk.

MAR 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/24

17

I HEREBY CERTIFY, That I attended deceased from 3/5/24, 19..., to 3/17/24, 19..., that I last saw h— alive on 3/13/24, 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lung abscess
(No history of any previous infection).

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 3/10/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) K. W. Dolly, M. D.

19 (Address) Mercy Hospital

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAR 24 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
COMMISSIONER OF HEALTH.
Per. A. M. WOODALL.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 6-9-19—H. P. Co. 1000 Bks.

D 85206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 85206

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 504 Moore Alley ST. 17 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James Henry Taylor Jr

(a) RESIDENCE. No. 504 Moore Alley ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James H. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Blanche Weathers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant
(Address)

Filed MAR 24 1924 Robert P. Harris, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1924, to Mar 24, 1924, that I last saw h[illegible] alive on Mar 23, 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

(duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Grantland M. D.

(Address) 334 N. Paddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85207

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 85207

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S. Green ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Milton Opher

(a) RESIDENCE NO. 504 S. Green ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June, 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Opher

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Gertrude Tilghman

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co (State or country) Maryland.

14 Informant John W Opher (Address) 504 S. Green

15 Robert P. Harrison, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar, 13, 1924 to Mar, 22 1924.

that I last saw him alive on Mar, 22 1924,

and that death occurred, on the date stated above, at 12 25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dan Francke, M. D.

3/22 1924 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOV Mad Cantagy Laybrisland DATE OF BURIAL Mar 25/ 19 24

UNDERTAKER Inc. Gerth Horse ADDRESS 406 Mc

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 24 1924

Cor.—1-12-23—M&T—100 Bks.

D 85208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85208

CERTIFICATE OF DEATH.

167-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 726 N. 34th. (ST.,) 13 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna M. Kaylor

(a) RESIDENCE NO. 726 N. 34th. ST., 13 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Kaylor

6 DATE OF BIRTH (month, day, and year) Sept. 20-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kilmington Del

PARENTS

10 NAME OF FATHER Edward A. Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kilmington Del.

12 MAIDEN NAME OF MOTHER Rebecca Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kilmington Del.

14 Informant John M. Kaylor
(Address) 726 N. 34th St.

15 MAR 24 1924 Robert P. Harrison, Registrar
16 192 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Timmons, M. D.
(Coroner.)
March 24, 1924 (Address) 5732 Roland Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 26 1924
20 UNDERTAKER Horace A. Burgee	ADDRESS 363 Falls Rd.

INFORMATION, WITH CERTIFICATE OF THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85209

CERTIFICATE OF DEATH.

74-004

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5252 Copley ave St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Christiana Alder

(a) Residence No. 5252 Copley ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. F. Alder

6-DATE OF BIRTH (month, day and year): March 8-1859

7-AGE, 65 yrs. — mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: Dennis Kelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-Informant: Charles F. Alder

(Address): 5252 Copley Ave

15-Filed: Mar 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-22-24

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to March 22, 1924, that I last saw h— alive on March 22, 1924, and that death occurred, on the date stated above, at 1.10 a. m.

The CAUSE OF DEATH* was as follows:

(Duration) ....yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ..... M. D.

(Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL, March 25 1924

20-UNDERTAKER: Horace F. Burgee — ADDRESS 363 Falls Road

MAR 24 1924

NO. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Shenk)

D 35210 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 35210

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1510 Clepper Road St., 12 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edward J. Shenck

(Residence in Baltimore: No. 1510 Clepper Road St.; yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	W.	Single

6-DATE OF BIRTH. April 12 1923
(Month) (Day) (Year)

7-AGE. yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Child
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Sam T. Shenk

11-BIRTHPLACE OF FATHER, (State or Country). Da.

12-MAIDEN NAME OF MOTHER. Sadie Childs

13-BIRTHPLACE OF MOTHER, (State or Country). Da

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. T. Shenk

(Address) 1510 Clepper Road

15- Robert P. Harrison, 192
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar 23 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Morrison M. D.
(Coroner.)

Mar 23 1924 (Address) 3302 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Marys Hampden	March 25 1924

20-UNDERTAKER'S NAME AND ADDRESS
CHENOWETH & SON,
3617 CHESTNUT AVE.

MAR 24 1924

8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 85211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 N Broadway ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie May Johnson

(a) RESIDENCE. NO. #1306 N. Broadway ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Johnson

6 DATE OF BIRTH (month, day, and year) Jan 24 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 yrs	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Fannie Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Richard Johnson (Address) 1220 E Eager St

15 Filed MAR 24 1924 Robert P. Morrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 12 1925 to March 22 1924

that I last saw h[illegible] alive on March 22 1924

and that death occurred, on the date stated above, at 9 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mesenteric Metastasis. Pressure Asphyxiation 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) # W. D. Leyer M. D.

. 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 25 1924
20 UNDERTAKER	ADDRESS
Chenowith & Son	367 Chestnut Av

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. No. 23-1—E. & R.S.—400 Bks.

5-6 P.M. (Charles M. Baner) 85 Goldsby Place Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85212 CERTIFICATE OF DEATH. D 85212

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2548 N. Balto St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Baner

(a) Residence No. 2548 N. Balto St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. / mos. / ds. How long in U. S., if of foreign birth? 30 yrs. / mos. / ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 30th 1871

7-AGE 52 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Mahogany

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacturing Lumber Dealer

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER John Baner

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Elizabeth Saunders

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-(Informant) Emma Spencer

(Address) 2548 N. Balto St

15-(Filed) APR 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/24/24

17- I HEREBY CERTIFY, That I attended deceased from 3/24 1924 to 3/24, 1924,

that I last saw h[illegible] alive on 3/24, 1924,

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phys. Examination

(Signed) Henry Goldberg M. D.

3/25, 1924 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, or REMOVAL. Loudon Park. DATE OF BURIAL. Mar 26 1924

20-UNDERTAKER. H B Kephart ADDRESS 2256 Fred'k Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Sanders

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85213

CERTIFICATE OF DEATH.

51

D 85213

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 413 S Payson St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Agnes V. Sanders

(Residence in Baltimore: No. 413 S Payson St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. April (Month) 6 (Day) 1857 (Year)

7-AGE. 67 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Fuhrman

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Sanders

(Address) 1167 Hanlcock St

15-

Filed MAR 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. March (Month) 24 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

Arteriosclerosis Rheumatism

(Duration) .....yrs. 6 mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. ..... mos.....ds.

(Signed) James M Kenton M. D.
(Coroner.)

Mar 24 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	3/27 1924
20-UNDERTAKER.	ADDRESS
J. Fin McCully	130 E. Fort.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85214

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D 85214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 16 ST. WARD)

2-FULL NAME Curtis Leutner

(a) RESIDENCE No. 2748 Harlem ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	3	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md

PARENTS

10 NAME OF FATHER Harry Leutner

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Emma Lisch

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Harry Leutner
(Address) 2748 Harlem

15 MAR 25 1924 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1924, to March 24, 1924, that I last saw ~~him~~ alive on March 24, 1924, and that death occurred, on the date stated above, at 8:05 a m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

(duration) — yrs. 1 mos 29 ds.

CONTRIBUTORY (Secondary) Mastoiditis.

(duration) yrs. 1 mos. 13 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Feb 13-24

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) P. MacGowan, M. D.

3/25/24 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar 25 1924

20 UNDERTAKER Enoch Taylor ADDRESS 1600 N Mart

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85215

CERTIFICATE OF DEATH.

101 D 85215

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No. 620 W. Montgomery ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur Urquhart

(a) RESIDENCE NO. 620 W. Montgomery ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 17 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
✓	—	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Urquhart

11 BIRTHPLACE OF FATHER (city or town) Seneca
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Edith Johnson

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co
(State or country) Maryland

14 Informant Benjamin Urquhart
(Address) 620 W Montgomery

15 MAR 25 1924 ROBERT NORRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar, 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar, 21, 1924, to Mar, 23, 1924, that I last saw him alive on Mar, 23, 1924, and that death occurred, on the date stated above, at 10, P, m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dan Francken, M. D.

3/24 1924 (Address) 124 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Transfer DATE OF BURIAL 19

20 UNDERTAKER Jno. E. Hoffman ADDRESS 908 W Conway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 85216

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 85216

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 No. Mechanic ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lydia M. White

(a) RESIDENCE NO. 404 No. Mechanic ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. L. White

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. L. Smith

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz. Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Jas. L. White
(Address) 404 Mechanic St.

15 Filed MAR 25 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

March 24, 1924 (Address) 20 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Michael Md — DATE OF BURIAL 3-25 1924

20 UNDERTAKER George T. A. Gibson — ADDRESS 1735 Druid Hill Ave

N.B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85217 — 74 — D 85217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 523 Nelson Sr ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna R. Stevens

(a) RESIDENCE NO. 523 Nelson Sr ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Stevens

6 DATE OF BIRTH (month, day, and year) About 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 069
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Holton

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gaines

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Leo. Stevens
(Address) 523 Nelson St.

15 [illegible]

MAR 25 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

March 24 192 (Address) 28 Courtland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Mar 27 1924
20 UNDERTAKER Leon Hall	ADDRESS 753 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85218

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Michlinski

(a) Residence No. 2403 Foster ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Michlinski

6-DATE OF BIRTH (month, day and year) 1889

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Joseph Michlinski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Mary Zorowski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Hospital Records

(Address) M.T.H.

13- Filed MAR 25 1924 192 ROBERT R. KRAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 16 1924 to March 22 1924

that I last saw him alive on March 22 1924

and that death occurred, on the date stated above, at 8.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally, M. D

3-23-, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Ger. Mch 25 1924 DATE OF BURIAL.

20-UNDERTAKER. J W Ozazewski ADDRESS 1930 Eastern Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85219

CERTIFICATE OF DEATH.

91-002 ✓ D 85219

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 930 Hisquith St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosanna Farrell

(a) Residence No. 930 Hisquith St., 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of late Michael Farrell

6-DATE OF BIRTH (month, day and year) Not Stated

7-AGE. 63 yrs. 2 mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Patrick Duffy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

11- (Informant) Mr. James E. Farrell

(Address) 930 Arisquith St

13- Filed MAR 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25 1924

17- I HEREBY CERTIFY, That I attended deceased from 2/19 1924 to 3/25 1924

that I last saw h.. alive on 3/25 1924

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) asthma

(Duration) ....yrs....mos....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Dr Herman Koch M. D

3/25 1924 (Address) 914 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	March 28 1924
20-UNDERTAKER.	**ADDRESS**
Henry Koch Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 85220

D 85220

1-PLACE OF DEATH Pronounced dead at St. Joseph Hospital

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Novotny

(a) RESIDENCE NO. 984 Sterling St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Street Sweeper
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Novotny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Josephine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mrs. Nicholas Herzing
(Address) 984 Sterling St

15 Filed MAR 25 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Head- run over by coal truck.

(Inquest Mar 27/24)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Davis, M. D. (Coroner.)

Mar 25 24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 26 1924
20 UNDERTAKER	ADDRESS
Henry Koeck & Son	1301 E Eager

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85221

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85221

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 258 S. Bouldin St., No Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Landy J. Hales

(a) Residence No. 258 S. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 0 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male.

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Hales.

6-DATE OF BIRTH (month, day and year): Mch. 1-1860

7-AGE. 64 yrs. 0 mos. 27 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Washington R. Hales

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: R. A. Linsted

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

11- (Informant): Mrs. F. Hales

(Address): 258 S. Bouldin

15- MAR 25 1924 ROBERT J. WILLIAMS, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 23 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1922 to March 23 1924

that I last saw him alive on March 23 1924

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Mouth & Tongue

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

3/24 1924 (Signed) Frances Tilton M. D.

(Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel A.A.C. Md.	3/26 1924
20-UNDERTAKER.	ADDRESS
J. Fen McCully	130 E. Fort.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 85222

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Pine St. ST., 17 WARD)

2-FULL NAME Mrs. L. Johnson

(a) RESIDENCE NO. 514 N. Pine St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson (dead)

6 DATE OF BIRTH (month, day, and year) about 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer Calvert Station,

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Jane Johnson
(Address) 514 Pine St.

15 Filed MAR 25 1924 ROBERT P. KRAUTER Registrar
Burial Permit Filed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. C. Hennessy, M. D.
(Coroner.)

March 24 1924 (Address) 208 Redwood St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-25 1924
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85223

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1023 Hollins St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Meeth

(a) Residence No. 1023 Hollins St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) July 14 1866

7-AGE, 57 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Laurence Schaumburg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eva Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Conrad Schaumburg.
(Address) 102 S. Arlington Ave

15- MAR 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-23-1924

17- I HEREBY CERTIFY, That I attended deceased from 1/29/24. 19..., to 3/23/24. 19.....

that I last saw h-r alive on 3/22 19 24

and that death occurred, on the date stated above, at 5.50 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurg

Chr. Dilat. of Heart

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Fry M. D.

3/25, 1924 (Address) 9 Lowndes Ct

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 3-25th 1924
Dr Valls - Druid Hill Pk	
20-UNDERTAKER, Wm Chas A. G. Rohde	ADDRESS 1200 Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85224

CERTIFICATE OF DEATH.

D 85224

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 Sargent St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph T. Kelly

(Residence in Baltimore: No. 1312 Sargent St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Jan (Month) 14 (Day) 1899 (Year)

7-AGE. 25 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gas Collector
(b) General nature of industry, business, or establishment in which employed (or employer): John Hancock

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Wm. F. Kelly

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Emma Waring

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. F. Kelly

(Address) 1312 Sargent St

15-

Filed ..... 192.. ROBERT R. KRAMER, Registrar.

MAR 25 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 24 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows: Endocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Pueblo War Gas

Inspection (Duration) ....yrs. ....mos. ....ds.

(Signed) Jerome M. Fenton M. D. (Coroner.)

Mar 24 1924 (Address) 7 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Cathedral	Mar 27 1924

20-UNDERTAKER. Wm. Cook

ADDRESS 502 E Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WHITE PAPER, WITH COLORED LINE—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85225

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85225

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3533 Greenmount ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Bingley.

(a) RESIDENCE NO. 3533 Greenmount St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced? (write the word)
Female	White	Widow.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph P. Bingley.

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68.	5.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Jacob D. Summett.

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah Stanford

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Joseph E. Bingley.

(Address) 411 E 21st St

15 Filed MAR 25 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1924, to March 24, 1924, that I last saw her alive on March 23, 1924 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John L. Finley, M. D.

3/27, 1924 (Address) 3532 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 27 1924
20 UNDERTAKER	ADDRESS
Weaver Bros	502 E. North.

Spec.—1-12-23—M&T—500 Bks.

William Dawson

D 85226

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85226

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 St. Joseph's Hospital ST.) 27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dawson

(a) RESIDENCE NO. 4506 Walker Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ of Laura Dawson

6 DATE OF BIRTH (month, day, and year) Oct 17, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED Waitsman

(a) Trade, profession or particular kind of work Hotel

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER David Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER R. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Laura Dawson (Address) 4506 Walker Ave

15 MAR 25 1924 ROBERT R. KRAMER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 23, 1924, that I last saw h~~im~~ alive on March 22, 1924, and that death occurred, on the date stated above, at 10.45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Gastroenteritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Jones, M. D.

March 24, 1924 (Address) 422 Harpurst

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL March 26, 1924

20 UNDERTAKER Wm Crook

ADDRESS 507 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85227

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2942 E. Monument St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Eleanor Danz

(a) Residence No. 2342 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Danz

6-DATE OF BIRTH (month, day and year) April 28 1842

7-AGE. 82 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Jamer Ebne

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Mary Hemler

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant) Arno Stout

(Address) 2408 E. Monument

15- ROBERT R. KRAUTER, Clerk.

MAR 25 1924 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24-1924

17- I HEREBY CERTIFY, That I attended deceased from March 24 19 24 to March 24 19 24

that I last saw h.... alive on March 24 19 24

and that death occurred, on the date stated above, at ..... m

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Edward H. Leavell M. D.

3/25, 19 24 (Address) 4138 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Emmanuel Cem	Mar. 28., 1924
20-UNDERTAKER.	**ADDRESS**
Wm L. Miller	2334 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 N Schroeder ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Ross

(a) RESIDENCE NO. 219 N. Schroeder ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/26/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	2	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Alex. Ross

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Colbert

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant Ethel Ross
(Address) 219 N. Schroeder

15 MAR 25 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/17/1923 to 3/23/1924

that I last saw him alive on 3/23/1924

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis about 9 days

CONTRIBUTORY (Secondary) Autopsy (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Raymond Long M. D.

(Address) 908 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Mch 24 1924

20 UNDERTAKER Sam'l H. Chase & Son — ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 85229

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85229

CERTIFICATE OF DEATH.

94

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Died enroute to Johns Hopkins Hospital St. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Nelson

(a) RESIDENCE NO. 410 N. Durham St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 11/1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): school boy
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: James Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Katie Bowie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: James Nelson
(Address): RQP N. Durham St

15 Filed MAR 25 1924

ROBERT M. KRAUTER, Registrar
Bystander with Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Statieus Lymphaticus - beginning Meningitis - enlarged Thymus Gland

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Woolen, M. D.
(Coroner.)

Mar 25 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetary — DATE OF BURIAL: mar 25 1924

20 UNDERTAKER: Walter Davis — ADDRESS: 315 N. Eden

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85230

CERTIFICATE OF DEATH.

113

REGISTERED No. .....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett A. George

(a) RESIDENCE NO. 460 Gaywood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE: Years 1 Months 6 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Della Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 25 1924 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 14 - 1924 to Mar 24 1924

that I last saw him alive on March 24, 1924,

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Diarrhoea (not Dysentery)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. A. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 3/25 1924

20 UNDERTAKER: Mrs James H. Dennis — ADDRESS: 1303 Freastman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Diddie Briggs

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85231

CERTIFICATE OF DEATH.

31 D 85231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 Rutland Ave ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Diddie Briggs

(a) RESIDENCE NO. 801 Rutland Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —0

✓

6 DATE OF BIRTH (month, day, and year) 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress Ott.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Smithfield Va.
(State or country)

PARENTS

10 NAME OF FATHER William Briggs.

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Rosetta Hopson

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Jessie Briggs
(Address) 801 Rutland Ave

15 MAR 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 1923, 19 ... to March 22, 1924, that I last saw h alive on March 22 1924, and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) RX ..... M. D.

3/24 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smithfield Va	March 1924

20 UNDERTAKER P. G. Ellick

ADDRESS 1720 Eastlan Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85232

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85232

John Hopkins

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1647 E Fayette ST., 6 WARD)

2-FULL NAME Frances Lyles.

(a) RESIDENCE NO. 1647 E Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Old Va
(State or country)

PARENTS

10 NAME OF FATHER Wm T. Lyles

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Old Va

12 MAIDEN NAME OF MOTHER Clara Penn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Old Va

14 Informant Wm T Lyles
(Address) 1647 E Fayette St

15 F MAR 26 1924 GL Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries Accidental (Town)

(duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) Shock (duration) ..... yrs. 1 mos. ..... ds.

(Signed) Geo Edwin Ridell, M. D.

3/21/24, 192 (Address) 243 E Eray (Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria Va — DATE OF BURIAL March 26 1924

20 UNDERTAKER Mr-Mrs A S Pink — ADDRESS 1737 N Rose St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give NAME instead of street number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., ... WARD)

2-FULL NAME Francis Lyles

(a) RESIDENCE NO. 1647 E.Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Dec 23/1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	3	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Thos. Lyles

11 BIRTHPLACE OF FATHER (city or town) Alexandria (State or country) Va.

12 MAIDEN NAME OF MOTHER Clara Penn

13 BIRTHPLACE OF MOTHER (city or town) Alexandria (State or country) Va.

14 Informant Wm. Thos. Lyles
(Address) 1647 E.Fayette St.

15 Filed 4/1/24 192 ..... Registrar.
Mailed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20/24 192

17 I HEREBY CERTIFY, That I took charge of remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd.& 3rd. burns over body & arms- clothing caught fire while playing with matches (Accidental)

(duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. .....

(Signed) J. S. McCallum (Coroner.)

Mar 20 24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accident, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos.,

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Cor.—1-12-23—M&T—100 Bka.

D 85233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 N. Bond St ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret G Donnelly

(a) RESIDENCE NO. 1208 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Donnelly

6 DATE OF BIRTH (month, day, and year) June 15/1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Michael O'Brein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. B.Frederick
(Address) 1208 N. Bong St

15 Filed MAR 26 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency (Probably)

(Found dead in bed)

(duration) yrs. mos. ds.

CONTRIBUTORY Senility)
(Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Wallis, M. D.
(Coroner.)

Mar 25/24 192 (Address) 508 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pastucka's Cemetery

DATE OF BURIAL 3/26 1924

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Harford Ave

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

B 85234

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85234

CERTIFICATE OF DEATH

1-PLACE OF DEATH Chelsea & Cedar (No.) 15 ST., (WARD) 161

CITY OF BALTIMORE, (No.) ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard William Rohrbach

(a) RESIDENCE NO. Chelsea & Cedar Pl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day / 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Rohrbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillie Fuhrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Harry Rohrbach Cedar & Chelsea

15 Filed , 19 Registrar

MAR 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1924

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to March 24, 1924.

that I last saw him alive on March 24, 1924.

and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Premature — Child

about 6½ or 7 mos —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Riblett, M. D.

3/24/24, 19 (Address) 2220 Garrison Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Conn — DATE OF BURIAL March 26 1924

20 UNDERTAKER Schlosman Son — ADDRESS 1034 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85235

CERTIFICATE OF DEATH.

D 85235

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 4423 Yeamans Lane St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Alleta Holt

(a) Residence No... 4423 Yeamans Lane St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~ Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick Holt

6-DATE OF BIRTH (month, day and year) Nov 4 1843

7-AGE, 80 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, William Jacobs

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Mrs Anna Jones

(Address) 4423 Yeamans Lane

15-

Filed ....., 192.. ..... Registrar.

MAR 26 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25/24

17- I HEREBY CERTIFY, That I attended deceased ~~from~~ on March 24, 1924 ~~to~~ ....., ~~to~~ ....., that I last saw her alive on ..... March 24, 1924 and that death occurred, on the date stated above, at 12.15 a m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C D Hoffmann M. D.

3/25, 1924 (Address) 3949 Greenmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Hope Cemetery | DATE OF BURIAL, March 27, 1924

20-UNDERTAKER, Williamson | ADDRESS 502 E Baltimore

Cor.—1-12-23—M&T—100 Bks.

Dr Riley

D 85236

HEALTH DEPARTMENT—CITY OF BALTIMORE

3M

D 85236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 427 North High ST., 5 WARD)

2-FULL NAME Charles Edwards

(a) RESIDENCE NO. 427 North High ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lydia Edwards

6 DATE OF BIRTH (month, day, and year) April 19, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER William Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Lydia Edwards
(Address) 427 N. High Street

15 Filed MAR 26 1924 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmon tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Riley, M. D.
(Coroner.)
March 26, 1924 (Address) 1659 Bower

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	3/27 1924
20 UNDERTAKER	ADDRESS
William Cook	502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 505 Poplar Grove St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus J. K Stanley Jr

(a) Residence No. 505 Poplar Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Laura Elma

6-DATE OF BIRTH (month, day and year) 5-5-1854

7-AGE. 69 yrs. 10 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baggage Master

(b) General nature of industry, business, or establishment in which employed (or employer): P.R.R. Co

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS.

10-NAME OF FATHER: John C Stanley

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa

12-MAIDEN NAME OF MOTHER: Frances Kerlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Penna

14- (Informant) Augustus J. K. Stanley

(Address) Mount Kingsburg Pa

15- MAR 26 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-24-24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1924 to March 24 1924

that I last saw h. alive on March 24, 1924

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

a Carcinoma of Liver

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. J. F. Hennessy M. D

March 24 1924 (Address) 2802 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lancaster Pa

DATE OF BURIAL: 3/26 1924

20-UNDERTAKER: Wm Cook

ADDRESS: 502 E. North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85238

CERTIFICATE OF DEATH. 20 118

D 85238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1 PLACE OF DEATH U.S. Marine Hospital Baltimore Md ST., 12 WARD)

CITY OF BALTIMORE; (No.

2-FULL NAME Ramon Coromina

(a) RESIDENCE NO. U.S. Marine Hospital #1 ST., WARD

(Usual place of abode) Baltimore Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Cook. 086

(c) Name of employer S/S Trade Gulf S/S Co

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Un known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un known

12 MAIDEN NAME OF MOTHER Un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un known.

14 Informant Self (Address)

15 Filed MAR 26 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Tuesday 3/25/19/24.

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924 to March 25, 1924.

that I last saw him alive on March 25, 1924.

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia, Bronchial.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Operation for Hernia, Feb 12, 1924

Comp. before death (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? U.S. Marine Hospital #1

Did an operation precede death? Yes Date of Mar 15 1924.

Was there an autopsy? No.

What test confirmed diagnosis? Physical but Pathology.

(Signed) W. N. Hall M. D.

19 (Address) U.S. Marine Hospital #1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL 3/26/1924

20 UNDERTAKER Joe Kinsor & Bro

ADDRESS 1127 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85239

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5403 Longwood ave ST., 27 WARD)

2-FULL NAME Emily W. Zimmerman

(a) RESIDENCE No. 5403 Longwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Zimmerman

6 DATE OF BIRTH (month, day, and year) Feby 11 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emily E. Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant James J. Zimmerman

(Address) 5403 Longwood ave

MAR 26 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw her alive on about 1 Month ago 19.....,

and that death occurred, on the date stated above, at 1. 00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Charles J. Wells M. D.

, 19 (Address) 7 W Belvedere Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 27 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. Northern

Spec.—8-24-14—M. & T.—2000 Bks.

D 85240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Childrens Hospital School

REGISTERED NO. C 12 35

CITY OF BALTIMORE: (No. Green Spring Ave. and 41st St St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bosley

(Residence in Baltimore: No. 319 East Lafayette Ave. St.; 13 yrs., 5 mos. 18 da.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, October (Month) 7 (Day), 1919 (Year)

7-AGE,	If LESS than 1 day,
13 yrs. 5 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Charles Lee Bosley

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, Maryland

12-MAIDEN NAME OF MOTHER Ida May Williams

13-BIRTHPLACE OF MOTHER (State or Country), Hagerstown, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. T. Shands, Jr.

(Address) Childrens Hospital School

15- MAR 26 1924 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 21 1923, to March 25 1924, that I saw him alive on March 24 1924, and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Left Hip Joint

(Duration) 3 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Amyloid Disease

(Duration) yrs. 4 mos. ds.

(Signed) Rev. E. Bennett M. D.

Mar 26, 1924. (Address) 4 E. Madison St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 25 ds. In the State 1 yrs. 1 mos. 25 ds.

Where was disease contracted, if not at place of death? 319 East Lafayette Ave.

Former or usual residence 319 East Lafayette Ave.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	3/27, 1924

20-UNDERTAKER	ADDRESS
Henry W. Means & Son	80 S. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85241

CERTIFICATE OF DEATH.

49 D 85241

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument 1 ST. 6 WARD)

2-FULL NAME Mrs. Yudes Jacobs.

(a) RESIDENCE NO. 2326 E. Balto. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David L. Jacobs

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 64 | Months — | Days — | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Aaron L. Barkan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Levis 1429 E. Baltimore St

15 MAR 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1924, to March 25, 1924, that I last saw her alive on March 25, 1924, and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of Pancreas

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of March 24, 1924

Was there an autopsy? no

What test confirmed diagnosis? clinical and operation

(Signed) Isidor L. Rawitz, M. D.

Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew

DATE OF BURIAL: 3/26 1924

20 UNDERTAKER: Jack Levis 1429 E Balto St

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

Salm

D 85242 HEALTH DEPARTMENT—CITY OF BALTIMORE 43 D 85242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St Agnes Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wm G Fahn

(a) Residence No. 1505 W Fayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Fahn

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe Factory
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) "

11-Informant Mrs Fannie Fahn

(Address) 1505 W Fayette St.

15-Filed MAR 26 1924 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25-24

17-I HEREBY CERTIFY, That I attended deceased from Feb 11- 19 24 to March 25 19 24

that I last saw h... alive on March 25 19 24

and that death occurred, on the date stated above, at 10 15 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma Jaw

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/1/23

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H. H. Harper M. D

19 (Address) Hebrew Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Rebrew Herringbone — DATE OF BURIAL. 3/26 19 24

20-UNDERTAKER. Jack Lewis — ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85243

CERTIFICATE OF DEATH.

100 D 85243

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Eastern av ST., 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo R. Hussey

(a) RESIDENCE NO. 2701 Eastern av ST., 1st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Hussey

6 DATE OF BIRTH (month, day, and year) Jan. 6-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	55	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) Vaudeville

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Cote, Guardeau Mon.

PARENTS

10 NAME OF FATHER James E. Hussey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cote Niel

12 MAIDEN NAME OF MOTHER Columbia Randdal

13 BIRTHPLACE OF MOTHER (State or country) Cote Guardeau Mon.

14 Informant Annie Hussey

(Address) 2701 Eastern Ave

15 Filed MAR 26 1924 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1924, to March 23, 1924, that I last saw him alive on March 23, 1924, and that death occurred, on the date stated above, at 12.35 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) O. L. Long M. D.

3/24, 1924 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL March 26, 24

20 UNDERTAKER Zirkler + Zirkler — ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85244

Spec. 1-6-24—D.—Bltf. Co.—1000 Bks.

D 85244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1604 Jackson ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecil Dawson

(a) RESIDENCE. No. 1604 Jackson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Dawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary McHale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Dawson

(Address) 1604 Jackson st

15 [illegible] 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.25 1924

17 I HEREBY CERTIFY, That I attended deceased from 3.14.24 19 . to 3.25.24 19 , that I last saw him alive on 3.25.24 19 , and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

measles

(duration) yrs mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physician.

3.25. 1924 (Signed) Edward Norris M. D.

(Address) 107 E west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	3-26 1924
20 UNDERTAKER	ADDRESS
Chas L. Stevens	1501 E Fort ave

MAR 26 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85245

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85245

24-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1914 N. Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Burton

(Residence in Baltimore: No. 1914, N. Charles St.; yrs., mos., ds.) 25

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Sept. (Month) 5 (Day) 1853 (Year)

7-AGE: 70 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Unknown.

11-BIRTHPLACE OF FATHER, (State or Country): "

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER, (State or Country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Burton

(Address) 1914 N. Charles St

15- MAR 26 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 25 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) Chas. F. Mossissee M. D. (Coroner.)

Mar 26, 1924 (Address) 3692 Roland Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Union Cemetery Baltimore Md. DATE OF BURIAL, Mar 26, 1924

20-UNDERTAKER, Harry D. Wirtz & Co. ADDRESS 153 W. Fayette St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

D 85246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85246

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3033 Westwood Ave. ST., 15th WARD)

2-FULL NAME Jacob T. Lewis

(a) RESIDENCE NO. 3033 Westwood Ave ST., 15 WARD .....
(Usual place of abode) (If non-resident ~~give~~ city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth H. Leister

6 DATE OF BIRTH (month, day, and year) Nov. 3 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Washington
(State or country) D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Mrs Frank Lewis
(Address) 3033 Westwood Ave

Filed MAR 26 1924

ROBERT R. KRAUTH,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to March 25, 1924, that I last saw him alive on March 24, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 11 mos 17 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. L. Wilkinson, M. D.

3/25, 1924 (Address) Rockville, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 27 1924
20 UNDERTAKER	ADDRESS 1944
Harry W. Ehlen	W. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85247

D 85247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chilham Rd. ST., Mt. Washington 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christine Wiese

(a) RESIDENCE NO. Chilham Rd. Mt Washington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Wiese

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Blume

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Jno. F. Hoffmaier
(Address) Chilham Rd. Mt Washington

15 MAR 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1924, to Mar. 25, 1924.

that I last saw her alive on Mar. 24, 1924

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of neck of bladder

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Cystoscopic Exam.

(Signed) E. B. Britton, M. D.

Mar 25 1924 (Address) 1711 E Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 26 1924
20 UNDERTAKER Henry H. Kerby & Co.	ADDRESS Edmondson Ave-College

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2400 Linden Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Bertha Katz

(a) Residence No. 2400 Linden Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Katz

6-DATE OF BIRTH (month, day and year): April 20/1876

7-AGE: 47 yrs. 11 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS

10-NAME OF FATHER: Louis Kaufman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Babette Harris

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Louis Katz

(Address): 2400 Linden Ave

Filed MAR 26 1924 192.. .....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 24/1924

17- I HEREBY CERTIFY, That I attended deceased from January 9 1924, to March 24 1924, that I last saw h.. alive on March 24 1924 and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Left)

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Metastasis to Bones—1 year

Myocarditis

(Duration) — yrs. 2 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Radioscopic

(Signed) Louis P. Hamburger M. D

, 19 (Address) 1207 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Alex Sheshan — DATE OF BURIAL: March 26, 1924

20-UNDERTAKER: David Sondheim — ADDRESS: 118 So Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/85249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Payson ST., 19 WARD)

2-FULL NAME Mr. John E. Graham

(a) RESIDENCE NO. 1517 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Graham

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 036

(b) General nature of industry, business, or establishment in which employed (or employer) Horse-Shoer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm J. Graham

(Address) 1403 N. Collington Ave

MAR 26 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 20 - 1924

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 24, 1924,

that I last saw him alive on March 24, 1924,

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) one yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gastric analysis & X-ray

(Signed) H. Andrews, M. D.

3/25/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Mar 28 1924

20 UNDERTAKER Chas. P. Evans & Son — ADDRESS 118 W. 28th St Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

D 85250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85250

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1119 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Margaret Retta Baldwin

(a) Residence No. 1119 Poplar Grove St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Zachariah Baldwin

6-DATE OF BIRTH (month, day and year) March 23 1867

7-AGE. 57 yrs. 0 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Frederick Hagner

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Wesley

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs. John W. Diven

(Address) 1119 Poplar Grove St.

15- Filed, 1924 16- Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24 1924

17- I HEREBY CERTIFY, That I attended deceased from March 19th 1924 to March 24 1924

that I last saw her alive on March 24 1924

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with decompensation.

(Duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) 1 yrs. 1 mos. 1 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis? -

(Signed) Frederick J. Boerlen M. D.

, 19 (Address) Halethorpe Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. | DATE OF BURIAL Mar. 26 1924

20-UNDERTAKER Joseph B. Cox & Co. | ADDRESS 1003 N. Bath St.

Spec—12-23-21—E.B.R.S.—4[illegible] Blks.

D 85251 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85251

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 880 West Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Clinton Johnson

(a) Residence No. 880 West Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Singl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 14, 1881

7-AGE.	If LESS than 1 day,
43 yrs. 1 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Piano Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Johnson & Kennedy

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, George W. Johnson

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Taturn

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-

(Informant) Mrs. Mary Johnson

(Address) 880 W. Fayette Street

15-

Filed MAR 26 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 20 1924, to March 23 1924, that I last saw h[illegible] alive on Mar 20 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3-24, 1924 (Address) 933 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet Cemetery	March 27 1924
20-UNDERTAKER Jos B Cook	ADDRESS 1003 N Bal St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85252

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Ziegler

(a) RESIDENCE NO. 21 N. Belmont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced) HUSBAND of (or) WIFE of John Ziegler

6 DATE OF BIRTH (month, day, and year) May 17 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Helper in
(b) General nature of industry, business, or establishment in which employed (or employer) Foundry
(c) Name of employer do

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Ziegler

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kerr

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Julia Ziegler
(Address) 21 N. Belmont

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Riley, M. D.
(Coroner)

Mch 25, 1924 (Address) 1659 Bruns

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cathedral	Mch 26 1924
20 UNDERTAKER John F. Welsh	ADDRESS 1700 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85253

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mun. Hospital ST. 25 WARD)

2-FULL NAME Bentie Herald.

(a) RESIDENCE NO. 2225 Wash. Blvd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 7th 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	✓	18		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George A. Herald.

11 BIRTHPLACE OF FATHER (city or town) Balt
(State or country) md.

12 MAIDEN NAME OF MOTHER Anna Rose Gutterberg

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Ricardo
(Address)

15 Filed ..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/16/ 1924 to 3/24 1924

that I last saw h alive on 3/24 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Empyema.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Sudden Cardiac failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home address.

Did an operation precede death? Yes Date of 3/21/24.

Was there an autopsy? .....

What test confirmed diagnosis? —

(Signed) W Wallace Walker M. D.

19 (Address) Lombard & Green Sts University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 26 19 24
20 UNDERTAKER	ADDRESS
Schofield	1200 W Fayette

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85254

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 120-W-University Parkway St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Catherine Schuster

(a) Residence No. 120-W-University Parkway St., 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? 69 yrs. 5 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of August Schuster

6-DATE OF BIRTH (month, day and year) Oct 8-1854

7-AGE.	If LESS than 1 day,
69 yrs. 5 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Henry Waltjen

11-BIRTHPLACE OF FATHER (city or town) not known
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine Moon

13-BIRTHPLACE OF MOTHER (city or town) not known
(State or Country), Germany

14- (Informant) Messrs Schuster (Sons)
(Address) Baltimore (414 N. Howard)

15- Filed MAR 26 1924 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 23-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 1, 192 4 to Mar 23, 192 4

that I last saw h alive on Mar 23, 192 4

and that death occurred, on the date stated above, at 11.40 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma duodenum

& Jaundice (Duration) yrs. mos. 2 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) E. [illegible], M. D.

Mar 26 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lorraine Cemetery	Mar 26, 1924
20-UNDERTAKER,	ADDRESS
[illegible] & MOWEN COMPANY (JOHN E. WOODEN, Successor)	108 W. [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN In plain terms, so that it may be properly classified. Exact statement of OCC instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85255 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2007 Maryland Ave St., 12 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin Charles Mister

(a) Residence No. 2007 Maryland Ave St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 ? yrs. ? mos. ? ds How long in U. S., if of foreign birth? 73 yrs. 7 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Mister

6-DATE OF BIRTH (month, day and year) July-29-1850

7-AGE. 73 yrs. 7 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Retired

9-BIRTHPLACE (city or town) Grenova

(State or Country) Mississippi

PARENTS.

10-NAME OF FATHER. Matthew K. Mister

11-BIRTHPLACE OF FATHER (city or town) Dorchester Co.

(State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Julia A. Lake

13-BIRTHPLACE OF MOTHER (city or town) Dorchester Co.

(State or Country) Maryland

14-

(Informant) Mrs Mary A. Mister (wife)

(Address) 2007 Maryland Ave

15-

Filed MAR 26 1924, 192.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24-1924

17- I HEREBY CERTIFY, That I attended deceased from Nov, 1923, to Mar 24, 1924

that I last saw h. alive on Mar 23, 1924

and that death occurred, on the date stated above, at 2-309 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) W. H. Pearce, M. D.

, 19 (Address) 2105 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery

DATE OF BURIAL, Mar 26, 1924

20-UNDERTAKER. HERBERT E. MOWEN COMPANY (HERBERT E. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is important. Information should be given in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85256

CERTIFICATE OF DEATH.

429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Deweese Beck

(a) RESIDENCE NO. Church Home & Infirmary ST., 6 WARD Elkins W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if of foreign birth? 85 yrs. 11 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Beck

6 DATE OF BIRTH (month, day, and year) March 26 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	85	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Winchester Virginia

PARENTS

10 NAME OF FATHER Deweese Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Penna

12 MAIDEN NAME OF MOTHER Elizabeth Isaak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Penna

14 Informant: Mrs A. J. Parsons (daughter)

(Address) 1814 Bolton St.

15 MAR 26 1924 19 H. Lass Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 28 1924

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to March 28, 1924.

that I last saw h[illegible] alive on March 25, 1924,

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

Nephritis Chronic

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Myocardial Insufficiency (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Cayetan Panettieri, M. D.

, 19 (Address) Church Home Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster - Md

DATE OF BURIAL: Mar 27 1924

20 UNDERTAKER: [illegible] MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

WARNING—THIS CERTIFICATE MUST BE PRESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should state AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 3907 Dait Ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philipa Greiser

(a) Residence No. 3907 Dait Ave St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise C. Greiser

6-DATE OF BIRTH (month, day and year): Aug. 8. 1899

7-AGE: 24 yrs. 7 mos. 15 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Broker

(c) Name of employer: Hambleton & Co.

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: William E. Greiser

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md.

12-MAIDEN NAME OF MOTHER: Julia A. Sturmfelz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md.

14-

(Informant): William E. Greiser

(Address): 1109 S. Ellwood Ave

MAR 26 1924 192 .... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 23/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 24th 1924 to Mch 23rd 1924

that I last saw h alive on Mch 23rd 1924

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

3/24/ 1924 (Signed) Robert S. Kirk M. D

(Address) 3126 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn Cem	March 26 1924
20-UNDERTAKER.	ADDRESS.
H. Sauder Sons	1710 Pleasant

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 85258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85258

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 621 S. Glover St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Rieth

(a) Residence No. 621 S. Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Rieth

6-DATE OF BIRTH (month, day and year) Aug 21, 1888

7-AGE. 35 yrs. 8 mos. 3 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS

10-NAME OF FATHER Adolph Herrmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER Caroline Meyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Charles H. Rieth

(Address) 621 S. Glover St.

15- MAR 26 1924 (Date Received) H. Dell Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1924 to March 24, 1924 that I last saw h alive on March 24, 1924 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Casimir Kwiatkowski M. D

. 19 (Address) 2529 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem	March 27, 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Kwiatkowski 2529 Eastern Ave

Spec.—1-10-21—M&T—1500 Bks.

D 85259 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 D 85259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2811 Mosher ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R VanSant Jr

(a) RESIDENCE NO. 2811 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L VanSant

6 DATE OF BIRTH (month, day, and year) Nov 23 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Dealer

(c) Name of employer F.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John R VanSant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Joanna Maher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Emma L. VanSant
(Address) 2811 ~~Lafayette~~ Mosher St

15 MAR 26 1924 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1924 to Mar 23, 1924

that I last saw him alive on Mar 23, 1924

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place Death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John R VanSant M. D.

3/25, 1924 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Mar 27 1924
20 UNDERTAKER John H. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 85260 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 85260

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 E. Church St ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Worthen.

(a) RESIDENCE NO. 126 E. Church St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow

5a If married, widowed, ~~or divorced~~ — ~~HUSBAND of~~ (or) WIFE of William D. Worthen.

6 DATE OF BIRTH (month, day, and year) July 21, 1849-

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Sauerhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Susan Culley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant William D. Worthen (son)

(Address) 126 E. Church Street

15 Filed MAR 26 1924, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924. to March 23, 1924.

that I last saw her alive on March 23, 1924.

and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & Kidneys.

(duration) -- yrs. 6 mos -- ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) -- yrs. -- mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto H. Reinhardt, M. D.

3-24 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL Mar 26 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerry O'Brien

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	4-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): City
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Alabama

PARENTS.
10-NAME OF FATHER, ?
11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?
12-MAIDEN NAME OF MOTHER, .
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records
(Address) .....

15- MAR 26 1924 192.. H. A. Mills Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-22-24

17- I HEREBY CERTIFY, That I attended deceased from 3-22 1924 to 3-22 1924 that I last saw him alive on 3-22 1924 and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculosis of Kidney (?)

(Duration) ..... yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude J. Dehaven M. D.

3-24 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cedar Hill	Mar 26 1924

20-UNDERTAKER,	ADDRESS
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 85262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85262

CERTIFICATE OF DEATH.

REGISTERED NO. C 8 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2514 E Preston St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M. Harper

(Residence in Baltimore: No. 2514 E Preston St.; 30 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, September 17, 1839 (Month) (Day) (Year)

7-AGE, 84 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Funkstown Md.

PARENTS.

10-NAME OF FATHER, Jacob Shamberger

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Sophia Grosch

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary J. Harris

(Address) 2514 E Preston St

15- MAR 26 1924 191.... D. A. M. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1924, to March 25 1924, that I saw h er alive on March 24 1924, and that death occurred, on the date stated above, at 12 N m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. 5 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) 7 yrs. 6 mos. ds.

(Signed) Thos J. U. Stevens M. D.

3/25, 1924 (Address) 2878 Hartford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Martinsburg W. Va. DATE OF BURIAL, March 27 1924

20-UNDERTAKER Richard F. Curley ADDRESS 1108 Gay St

Spec. 6 (Mar. 31 '24) Co.—1000 Bks.

D 35263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85263

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3520 Myrtle Place ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew F. Mc adams

(a) RESIDENCE. No. 3520 Myrtle Pl. ST., 6 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Owen Mc adams

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Mary Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Mc adams

(Address) 3520 Myrtle Place

Filed MAR 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to March 24, 1924, that I last saw h[illegible] alive on March 22, 1924, and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) M J McCarty, M. D.

3/25. 1924 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	3/27 1924
20 UNDERTAKER	ADDRESS
John J. Moran	3 ab E. Biddle St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] CUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85264

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85264

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 2125 W. Saratoga St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret S. Shafer

(a) Residence No. 2125 W. Saratoga St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W. White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 7-1838

7-AGE,	If LESS than 1 day.
85 yrs. 10 mos. ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... do

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Francis J. Schafer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sarah Damm

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant)..... Ely. Schafer

(Address)..... 2125 W. Saratoga

MAR 26 1924

19..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 24/24

15- I HEREBY CERTIFY, That I attended deceased from Jany 1 19 24 to March 23 19 24

that I last saw h.. alive on March 23 19 24

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(Duration) yrs. mos. ds. Unknown

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Wm. O'Neill M. D.

3/24. 1924 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greenmount Cemetery	3/27 19 24
20-UNDERTAKER, J. A. Moran	ADDRESS 3009 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85265

CERTIFICATE OF DEATH.

90

D 85265

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 Fork. ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Raynor.

(a) RESIDENCE. No. 1034 Fork- ST., 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Raynor.

6 DATE OF BIRTH (month, day, and year) Aug 10. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annes Bonal Co

PARENTS

10 NAME OF FATHER Zachariah Harvey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant John Raynor. (Address) 1034 Fork.

MAR 26 1924 G.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1924, to Mar. 24, 1924, that I last saw her alive on Mar. 23, 1924, and that death occurred, on the date stated above, at 10-10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. T. Seabury M. D.

3/24. 1924 (Address) 638 Fork.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	March 27 1924

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fort Ave

(Buchan)

D 85266 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C 90

City of BALTIMORE: (No. 2415 Ellum St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Buchan

(Residence in Baltimore: No. 2415 Ellum St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	C.	Single

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE. 43 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country): Balto Co Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): "

12-MAIDEN NAME OF MOTHER: "

13-BIRTHPLACE OF MOTHER, (State or Country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Buchan

(Address) 2415 Ellum st

15- Filed MAR 26 1924 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 24 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Weiss M. D. (Coroner)

Mar 25 1924 (Address) 2671 Reliance

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Pine Grove (Balto Co) — DATE OF BURIAL: Mar 27 1924

20-UNDERTAKER: Joseph A Farrell — ADDRESS: 2314 Division st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

2-FULL NAME John Hardy

(a) RESIDENCE NO. 17 Gilbert (617) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 MAR 26 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 21 1924

17 I HEREBY CERTIFY, That I attended deceased from 2 - 12 , 1924 , to 3 - 21 , 1924.

that I last saw h alive on 3 - 21 , 1924

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

Myocardial Insufficiency

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext

(Signed) Claude G. Drane, M. D.

3-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae Cemetery	Mar 26 1924
20 UNDERTAKER	ADDRESS
Mrs R C Elliott	1725 Eastland Ave

Cor.—1-12-23—M&T—100 Bks.

D 85268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Dalton

(a) RESIDENCE NO. 1117 E. Monument St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Albert Dalton

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Indies

12 MAIDEN NAME OF MOTHER Bertha Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Bertha Wright Dalton
(Address) 1117 E. Monument St.

15 Filed MAR 26 1924 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute appendicitis-perforation
Peritonitis- partial bowel
obstruction (Operation & autopsy
at Hopkins Hospital) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Dallas, M. D. (Coroner.)

Mar 26/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	Mar 26 1924
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85269

CERTIFICATE OF DEATH.

V 31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 218 So. Duncan St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Martha Morris

(a) Residence No... 218 So. Duncan St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of:

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 40 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va

PARENTS.

10-NAME OF FATHER: Peter Crockett

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Emily Veney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

11- (Informant): Frank Morris

(Address) 218 So. Duncan St

15- Filed ..... 192.....

Registrar.

MAR 26 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 23/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 12, 1923, to March 23, 1924

that I last saw h alive on March 21, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary): Influenza

(Duration) ..... yrs. 7 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

3/24, 192 (Address) 1612 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery

DATE OF BURIAL, ... 192.....

20-UNDERTAKER: Mrs R. C. Elliott

ADDRESS 725 Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85270 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. St. Agnes' Hospital St. Charles Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Anderson Sheets

(a) Residence No. Smithfield, West Virginia Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-~~Single~~, Married, ~~Widowed~~, ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bertrude M. Sheets

6-DATE OF BIRTH (month, day and year) Nov 12th, 1888

7-AGE. 35 yrs. 5 (5) mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Wetzel County School Board

9-BIRTHPLACE (city or town) (State or Country): Harrison County W. Va.

PARENTS.

10-NAME OF FATHER, J. E. W. Sheets

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Harrison County W. Va.

12-MAIDEN NAME OF MOTHER, Vilena L. Campbell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Harrison County W. Va.

11-(Informant): Mother Vilena L. Campbell

(Address): Byford, W. Va.

13-Filed MAR 26 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-26-24

17- I HEREBY CERTIFY, That I attended deceased from 3/12 1924 to 3/26 1924

that I last saw him alive on March 25 1924

and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Tumor of the rectum -

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis following operation

(General) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Wetzel County W. Va

Did an operation precede death? Yes Date of 3/19/24

Was there an autopsy? No

What test confirmed diagnosis? opening unhealed incision

(Signed) H. V. Harper M. D

, 19 (Address) Shinnston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Smithfield West Va	3-26th, 1924
20-UNDERTAKER, Robert Brooks & Son	ADDRESS. S. E. Cor Calhoun Hollins St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE (Bourne)

D 85271

D 85271

CERTIFICATE OF DEATH.

9 101-00

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 E 33rd St.) ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Todd Bourne

(a) Residence No. 700 E 33rd St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-Single, Married, ~~Widowed,~~ or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C Bourne

6-DATE OF BIRTH (month, day and year) Oct 14 1877

7-AGE. 44 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Manufacturers Agt

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer [illegible]

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Locke Bourne

11-BIRTHPLACE OF FATHER (city or town) Liverpool
(State or Country), Eng

12-MAIDEN NAME OF MOTHER, Alice E Berry

13-BIRTHPLACE OF MOTHER (city or town) Washington
(State or Country), D C

11- (Informant) Mrs Alice E Bourne

(Address) 2301 Eutaw St

13- F MAR 26 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 25-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 8th, 1924, to Mar. 25, 1924, that I last saw him alive on Mar. 24, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

1. Obstruction of Pancreas
2. Myocardial Insufficiency
(Duration) ....yrs.....mos.....ds.
CONTRIBUTORY (Secondary) Lobar Pneumonia
(Duration) .....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Wm [illegible], M. D.

3/25, 1924 (Address) 1145 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Mar 27 1924
20-UNDERTAKER, Putnam Bros	ADDRESS 1723 Pulaski St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85272 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85272

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 3228 E. Fairmount Ave. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schmalbach

(a) Residence No. 3228 E. Fairmount Av. St., 26 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of the late Henry Schmalbach

6-DATE OF BIRTH (month, day and year) May 22nd 1850

7-AGE. 73 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Ret'd

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: John Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Mrs. William E. Bebe

(Address)

15- MAR 26 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch. 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1924 to March 23 1924 that I last saw h[illegible] alive on March 23 1924 and that death occurred, on the date stated above, at 4 40 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstat Nephritis

(Duration) 1 yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Maxwell L. Mayer M. D.

3/26 1924 (Address) 315 E Balt St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mch. 26th 1924
20-UNDERTAKER, Lilly + Zeiler	ADDRESS 4033 Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85273

154-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Patapsco St.: 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Ridge Jr.

(a) RESIDENCE. NO. 1103 Patapsco ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March-23-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Ridge Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Agnes Della Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Louis Ridge Sr
(Address) 1113 Patapsco St

15 Robert P. Harrison, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1924

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to March 24, 1924, that I last saw him alive on March 24, 1924, and that death occurred, on the date stated above, at 6.30A. m.

The CAUSE OF DEATH* was as follows:

Morbus Cerulens

1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Mitchell M. D.

3/27. 1924 (Address) 1279 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Md.	March 1924
20 UNDERTAKER	ADDRESS
C. A. Frazer & Son	703 E. Lanvale St

MAR 26 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED PAPER CO.

Spec.—1-10-21—M&T—1500 Bks.

D 85254 D 85274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... St., 7 Ward)

2-FULL NAME Frederick W. Sage

(a) RESIDENCE No. N. St Petersburg Fla. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 0/6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N Y

PARENTS

10 NAME OF FATHER A. H Sage

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant (Address)

15 Filed MAR 26 1924, 19 Registrar Robert P. Harrison,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1924, to Mar. 25, 1924, that I last saw him alive on Mar. 25, 1924, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer, hemorrhage and marked anaemia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebro-Spinal fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7

Did an operation precede death? No Date of March 26, 1925

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W Brafield Ky M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Plains, N. Y. DATE OF BURIAL March 26 24

20 UNDERTAKER John O Mitchell ADDRESS 1201 W. Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85275

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85275

CERTIFICATE OF DEATH. 185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 St. Roslyn Ave 15 WARD)

2-FULL NAME Mary Dupuy Robinson

(a) RESIDENCE NO. 2215 Roslyn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph S Robinson M.D.

6 DATE OF BIRTH (month, day, and year) Aug 27 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John T Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary C Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss Lucy Robinson

(Address) 2215 Roslyn ave

15 Robert P. Harrison, .19 Registrar

MAR 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 , 1923 , to March 23 , 1924 ,

that I last saw her alive on March 23 , 1924 ,

and that death occurred, on the date stated above, at 9:13 a m.

The CAUSE OF DEATH* was as follows:

Fracture - right hip - Dec 9/23 -
arteriosclerosis - (duration 15 yrs)
Fell off of chair in own home.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) E S Willett M. D.

3/29/24 19 (Address) 2220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Springs Va	March 26 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85276

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-006 ✓ 85276

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 S. Hilton ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward J Bradley

(a) RESIDENCE NO. 39 S. Hilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt (State or country)

PARENTS

10 NAME OF FATHER Jas. C Bradley

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country)

12 MAIDEN NAME OF MOTHER Ruby Gerhart

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country)

14 Informant Jas. Bradley (Address) 39 S Hilton

15 MAR 26 1924 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1924, to March 25, 1924, that I last saw him alive on March 25, 1924, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

of 6th Month

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Howard W Jones

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Mar. 28 24

20 UNDERTAKER Chas. W. Dill.

ADDRESS 3809 Fait Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-0-23—M&T—1500 Blks.

D 85277

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85277

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 118 W. Hill, ST., 27 WARD)

2-FULL NAME Spencer Turner

(a) RESIDENCE NO. 118 W. Henrietta ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Turner

6 DATE OF BIRTH (month, day, and year) June, 16, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or, ... min.
	29	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 130

(b) General nature of industry, business, or establishment in which employed (or employer) Shipyard Crane

(c) Name of employer H. E. Coon Co

9 BIRTHPLACE (city or town) Nelson Co

(State or country) Virginia

PARENTS

10 NAME OF FATHER Spencer Turner

11 BIRTHPLACE OF FATHER (city or town) Nelson Co

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Harriett Giles

13 BIRTHPLACE OF MOTHER (city or town) Nelson Co

(State or country) Virginia

14 Informant John Turner

(Address) 905 W. Mad St

Filed MAR 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1924, to Mar. 25, 1924,

that I last saw him alive on Mar. 25, 1924,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dan Franklin, M. D.

3/26 1924 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sherman Va.

DATE OF BURIAL March 27 1924

20 UNDERTAKER R. L. Parham

ADDRESS 923 Leadenhall St.

Spec.—8-24-14—M. & T.—2000 Bks.

D 85278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85278

CERTIFICATE OF DEATH.

REGISTERED NO. C 179

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Joseph Hosp ST.; 5 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Chandler

(Residence in Baltimore: No. 408 Forrest St.; 27 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Sept. (Month) 14 (Day), 1880 (Year)

7-AGE, 43 yrs. 6 mos. 10 ds.
If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel A. Annello

(Address) 1806 N. Broadway

15-

MAR 26 1924

Robert P. Harrison, M.D.
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 24 1924, to Mar 24 1924, that I saw her alive on Mar 24 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Coronary Intermittent Pulmonic
Mitral Regurgitation

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 1 ds.

(Signed) J. L. Pitcairn M. D.

Mar 25, 1924 (Address) 1038 N. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery

DATE OF BURIAL. Mar. 26, 1924

20-UNDERTAKER George Schilling & Sons

ADDRESS 1120 Eutaw St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85279

CERTIFICATE OF DEATH.

5-50

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Battle

(a) Residence No. 1408 Fairmount St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER, William Battle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Elsa Battle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Municipal Hospital Records

(Address).....

Filed ..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-19-24

17- I HEREBY CERTIFY, That I attended deceased from 2-27, 1924, to 3-19, 1924

that I last saw h~~e~~ alive on 3-19, 1924

and that death occurred, on the date stated above, at 3 45 p. m.

The CAUSE OF DEATH* was as follows:

Tumor of Mediastinum

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Brace, M. D.

3-19, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL, ... 19....

20-UNDERTAKER, J. WOODALL & SON

ADDRESS MAR 25 1924

MAR 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

1263

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Sterling

(a) RESIDENCE NO. 331 E. 21 & 1/2 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) ;ar 16/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Cecil $terling

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER Bessie Ducall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Johns hopkins Hospital
(Address)

Filed MAR 26 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity - 8 mons. Gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Whites, M. D. (Coroner)

Mar 22 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S mation should be properly classified. Exact statement of OCCU CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85281

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 19 WARD)

2-FULL NAME Eva Louise Bruscup (Eva Louise Bruscup)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1307 W. Pratt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A Bruscup

6 DATE OF BIRTH (month, day, and year) May 6, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	54	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Bergle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George A Bruscup (Address) 1307 W Pratt St

15 MAR 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1924, to March 26, 1924, that I last saw her alive on March 26, 1924, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. J. Plyfer M. D.

3-26 24 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mch 28 1924
20 UNDERTAKER	ADDRESS
Jos B Cook	1003 W Balto

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85282

CERTIFICATE OF DEATH.

15 75 D 85282

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3104 Clifton Avenue St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Ann Holland

(a) Residence No. 3104 Clifton Avenue St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow Widowed, or Divorced, (Write the word.)
Female	White	

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Holland

6-DATE OF BIRTH (month, day and year) Mar. 17, 1833

7-AGE.	If LESS than 1 day,
91 yrs. – mos. 7 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Canada

PARENTS.

10-NAME OF FATHER, William Mountain

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Salt

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). England

14- (Informant)....J. Monroe Holland.....

(Address).....3104 Clifton Avenue.....

15- [illegible] Robert P. Harrison, Registrar.

MAR 26 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 22, 1924, to Mar. 24, 1924

that I last saw her alive on Mar. 24, 1924, and that death occurred, on the date stated above, at 4.07 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis followed by general weakness which terminated in death

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) General Breakdown (Duration) yrs. 1½ mos. ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis R. Side

(Signed) Jessie A. Zapp, M. D.

3-25, 1924 (Address) 3043 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem	Mar. 26, 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Balto

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85283

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH 1142 n. Mount St, Colonial Hospital ST., 16 WARD)

CITY OF BALTIMORE: (No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Daisy Holbrunner

(a) RESIDENCE NO. 2033 W. Lafayette Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer. Holbrunner

6 DATE OF BIRTH (month, day, and year) Aug. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Aug. 54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa.

PARENTS

10 NAME OF FATHER Aaron Beck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Martha Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Elmer C. Holbrunner

(Address) Woodsboro Md.

MAR 26 1924

Robert P. Harrigan, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 5 , 1924, to , 19 ,

that I last saw her alive on Mar. 26 , 1924,

and that death occurred, on the date stated above, at 11.20 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast.

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) A. E. Ryland, M. D.

, 19 (Address) 330 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodsboro Md.	Mar 29 '24

20 UNDERTAKER E. & B. Harke 145 East West St

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85284

CERTIFICATE OF DEATH.

94 D 85284

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Henry Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Hunt

(a) RESIDENCE NO. 18 Henry Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23rd, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
X		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... no

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER See Hunt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Julia Berry

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. Carolina

14 Informant Julia Berry.
(Address) 18 Henry Ave

15 [illegible] Robert F. Harrison,
Registrar

MAR 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1924, to Mar 25, 1924,

that I last saw h— alive on Mar. 21, 1924,

and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Asthma

(duration) ... yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? "Rolling Creak Spells"

(Signed) Gustav F. Wolcenko, M. D.

March 1924 (Address) 1120 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-27 1924
20 UNDERTAKER David Easton	ADDRESS 966 Pa Ave

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85285

CERTIFICATE OF DEATH.

1747 D 85285

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1239 Myrtle Ave St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary A. H. Sides

(a) Residence No. 1239 Myrtle Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Columbus Sides

6-DATE OF BIRTH (month, day and year) 1855

7-AGE, 69 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Elijah Foot

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Annie Jackson

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) Columbus Sides

(Address) .....

15- Filed ..... Robert P. Harris ..... Registrar.

MAR 25 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-24-24

17- I HEREBY CERTIFY, That I attended deceased from March 10th, 1924, to March 24, 1924, that I last saw h.. alive on... March 24, 1924, and that death occurred, on the date stated above, at 6.30 ...m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jas A Carlyn, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR (Date) Laurel Cem. | DATE OF BURIAL, 3-28-, 1924

20-UNDERTAKER Dunc Easton | ADDRESS 916 Ba ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85286

CERTIFICATE OF DEATH.

90 D 85286

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Downes

(a) Residence No. 1201 161 Bolton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE,	If LESS than 1 day,
50 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Maryland (State or Country).

PARENTS.

10-NAME OF FATHER, Charles Downes

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

11- (Informant) Municipal Hospital Records

(Address)

15- Filed 3 6 1924 Robert P. Harrison, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-25-24

17- I HEREBY CERTIFY, That I attended deceased from 2-18, 1924 to 3-25, 1924 that I last saw him alive on 3-25, 1924, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Myocarditis
Myocardial Insufficiency
(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Drane, M. D.

3-25-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	3-27, 1924
20-UNDERTAKER	ADDRESS
Dent Easton	916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EX/CTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. E. act statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green Sts. 11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Johnson

(a) RESIDENCE NO. 225 W. Chase St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Johnson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant University Hospital Record
(Address)

15 MAR 26 1924 Robert P. Harrison Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-1924

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to March 26, 1924

that I last saw him alive on March 26, 1924

and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate with generalized metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic & laboratory

(Signed) William Walker M. D.

, 19 (Address) Lombard & Green Sts Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	3-29 1924
UNDERTAKER David Exford	ADDRESS 916 Pa ave

MARYLAND REGISTRATION—B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

27 199 D 85288

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospitals ST., ... WARD)

2-FULL NAME Marion Bryan

(a) RESIDENCE NO. 5013 Beauregard Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Athome
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Reistertown Md.

PARENTS

10 NAME OF FATHER: Clarence Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Reistertown Md.

12 MAIDEN NAME OF MOTHER: Maggie Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Sister
(Address): 5013 Beauregard Ave

15 Filed MAR 26 1924, 192... Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis- infection thru uterus- abortion (By whom performed, unable to ascertain)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Autopsy at Hopkins)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Walker, M. D. (Coroner.)

Mar 27/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reistertown Md.	3-27 1924

20 UNDERTAKER: Chas. Alexander ADDRESS: 1406 D. Hill Av

26.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85289

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hos St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margery Louise Crockard

(a) Residence No. 1024 N. Stricker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 6 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 1886

7-AGE. 37 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER Andrew Crockard

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER Adelaide Wittle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Miss Virginia Wittle
(Address) 1024 N. Stricker St

15- MAR 26 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 24 1924

17- I HEREBY CERTIFY, That I attended deceased from November 13 1923 to March 24 1924

that I last saw her alive on March 24 1924

and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Acute Bright's disease

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of Heart

(Duration) 2/12 yrs. mos. ds.

18-Where was disease contracted if not at place of death? yes

Did no operation precede death? yes Date of

Was there no autopsy? yes

What test confirmed diagnosis? Albumen Urine

(Signed) John L Pennington M. D

19 (Address) 1826 Bolton St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Mar. 26 1924

20-UNDERTAKER. Wm J Richardson & Son ADDRESS North Ave

Burial Permit start.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85290 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85290

CERTIFICATE OF DEATH. 181-003

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 15 WARD)

2-FULL NAME Dodie E. Ehlers.

(a) RESIDENCE NO. 2813 Kathy Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clifton S. Ehlers.

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48 yrs.	6	25.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 137
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Edmund Tompkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Suffolk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Interment Clifton S. Ehlers.
(Address) 2813 Kathy Ave

Filed MAR 26 1924, 192 Robert P. Harrison, Registrar

Burial Permit filed.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cocaine anesthesia
(Idiosyncrasy)
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart.
(duration) ..... yrs. ..... mos. 1 ds.

(Signed) Dr T. Hennessy, M. D.
(Coroner.)

March 26 1924 (Address) 210 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — DATE OF BURIAL Mar. 27 1924

20 UNDERTAKER H. J. Tuckner & Sons — ADDRESS North & Eastern Ave

MAR 26 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Blks. Homes of Good Shepherd

D 85291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85291

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 19 Ward) Registered No. 100-09

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Kynngll

(a) Residence No. Good Shepherd Convent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Don't Know

7-AGE, 12 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Inmate Good Shepard

(b) General nature of Industry, business, or establishment in which employed (or employer) Convent

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Washington D C

PARENTS

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14- (Informant) St Agnes Hospital

(Address)

15- Filed , 192 Robert P. Harrison, Registrar.

MAR 26 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 26/1924

17- I HEREBY CERTIFY, That I attended deceased from Mch 24 19 24 to Mch 26 19 24

that I last saw h alive on Mch 26 19 24

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 14 ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. Goldeman M. D

. 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Washington D C

DATE OF BURIAL, Mar 29 19 24

20-UNDERTAKER John Ullrick

ADDRESS 2008 Eden St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85292

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001
D 85292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Druid Hill Park St. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John William Wright

(Residence in Baltimore: No. 3411 Montebello Drive St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	married

6-DATE OF BIRTH, April 26, 1866
(Month) (Day) (Year)

7-AGE, 57 yrs. 10 mos. 30 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Wright

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Jane Talbott

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella A. Wright

(Address) 3411 Montebello Drive

15- Robert P. Harrison,
....., 191.....
Burial Permit Clerk Registrar.

MAR 26 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. P. Morrison M. D.
(Coroner.)

March 26, 1924 (Address) 2602 Reisterstown Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park Cemetery	March 28, 1924
20-UNDERTAKER	ADDRESS
E. LeRoy Stifflet	125 E. Natl. Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 85293

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2929 Presbury st ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Smith

(a) RESIDENCE. No. 2929 Presbury st ST., WARD Hereford Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband

6 DATE OF BIRTH (month, day, and year) Jan 18-1850

7 AGE: Years 74 Months 2 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nonn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER Thos Smyth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Roy Smyth

(Address) 2929 Presbury st

15 MAR 26 1924 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1923. 19 , to March . 1924

that I last saw h alive on March 25 1924

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Nephritis

(duration) Don't know yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) None Samuel M. D.

324 1924 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Mch 27 1924

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 125 E North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85294

CERTIFICATE OF DEATH.

91 1700

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 106 Dorchester ave ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Reilly

(a) RESIDENCE. NO. 106 Dorchester ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert M Reilly

6 DATE OF BIRTH (month, day, and year) March 30 40

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant C E Reilly

(Address) 106 Dorchester ave

15 [illegible] Registrar

MAR 26 1924

Registered MAR 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24. 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to March 24 1924

that I last saw her alive on March 24, 1924,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Senility

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) James L. Ashhurst, M. D.

3-Hollins (Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar 27 1924
20 UNDERTAKER	ADDRESS
W M Routson	2230 N Mts

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be filled out. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 W Franklin ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma V Downing

(a) RESIDENCE No. 607 W Franklin ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Downing

6 DATE OF BIRTH (month, day, and year) Aug 22 '46

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	77	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John J Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs R B Kenyon

(Address) 607 W Franklin

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

MAR 26 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1924, to Mar 26, 1924.

that I last saw her alive on Mar 26, 1924,

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) 0 yrs. 0 mos 12 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) R B Kenyon M. D.

M 26 1924 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL March 28 1924

20 UNDERTAKER W M Renton

ADDRESS 2238 N Mott

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85296

CERTIFICATE OF DEATH.

101-001 B 85296

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Fremont ST.: 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Taylor

(a) RESIDENCE. NO. 412 N. Fremont ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Levy Rawlings

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Eliz a Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Eliza Rawlings
(Address) 412 N. Fremont

15 Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 25, 1924,
that I last saw h alive on March 25, 1924,
and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Do Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical Examination

(Signed) Charles H. Howard, M. D.

(Address) 712 S. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3-27 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 1902 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 85297

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 828 Clorey st St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Evelyn Coates Bernard

(Residence in Baltimore: No. 828 Clorey st St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Sngle

6-DATE OF BIRTH, Feb (Month) 23 (Day) 1919 (Year)

7-AGE, 5 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER. Jos coates

11-BIRTHPLACE OF FATHER, (State or Country). md

12-MAIDEN NAME OF MOTHER, Emma Wilson

13-BIRTHPLACE OF MOTHER, (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Coates

(Address) 828 Clorey St

15- MAR 27 1924 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 24 (Day) 192.. 24 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(Inquest, autopsy or inquiry.) find that said deceased came to.....her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tobac Pneumonia

about 2 weeks'

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Bowel Trouble

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

192.. (Address) 828 E. Clorey St 113 N. Gaylord St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, 3-27 192..

20-UNDERTAKER, John H. Trader — ADDRESS 142 Ostend St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor. 1-M-3-M&T—100 Bks.

D 85298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85298

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1445 Eastern ST., 3 WARD)

2-FULL NAME Jacob Brackley

(a) RESIDENCE NO. 1445 Eastern Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rev Johnson
(Address) 1416 Eastern ave

15 Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Edgewood (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. M. C. Slade, M. D.

3/27/24 (Coroner.) 192 (Address) 1430 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemy	Mar 192 4
20 UNDERTAKER Geo J Ruth	ADDRESS 1735 Hoffman ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 85299

D 85299

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 2900 Westwood Ave ST.: 15 74 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Dammier

(Residence in Baltimore: No. 2400 Westwood St.; ...yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Single

6-DATE OF BIRTH: ..... (Month) ..... (Day), 1857 (Year)

7-AGE: 65 yrs. — mos. ... ds. If LESS than 1 day, ... hrs., or ... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Packer
(b) General nature of industry, business, or establishment in which employed (or employer): McCormick & Co.

9-BIRTHPLACE (State or country): Balto City.

PARENTS

10-NAME OF FATHER: Lindsey Himler

11-BIRTHPLACE OF FATHER (State or country): Germany.

12-MAIDEN NAME OF MOTHER: Mary Messersmith

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lindsey Stromyer

(Address) 2900 Westwood Ave

MAR 27 1924 Filed ..... 191.....

ROBERT R. KRAUTER, Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: March (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 25 1924, that I saw h.. alive on March 25 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 3 yrs. ... mos. ... ds.

Contributory (SECONDARY) Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

(Signed) Frank G. Heller M. D.

March 26, 191 [Address] 2838 Gwynn

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western Cem. DATE OF BURIAL: March 27, 1924

20-UNDERTAKER: Martin Haley Sons ADDRESS: 527 W. Worth

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85300

100-001

D 85300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST. 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter J Bragan

(a) RESIDENCE NO. St Vincents Asy ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 MAR 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 19 1924, to Mar 21 1924, that I last saw h... alive on Mar 21 1924, and that death occurred, on the date stated above, at 6 40 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. None ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Edmund H Kemper, M. D.

3/22, 1924 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 27 1924
20 UNDERTAKER	ADDRESS
Martin Bailey Son	1811 W North.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8530L

46

CERTIFICATE OF DEATH.

D 8530L

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Myrtle Ave ST., 4 WARD)

2-FULL NAME Julia Celstia Gross

(a) RESIDENCE NO. 210 Myrtle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph B. Gross

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 51 — Months — Days — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): St Mary Co. Md.

PARENTS

10 NAME OF FATHER: Jeff Semper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jane Blair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Joseph B. Gross

(Address): 210 Myrtle Ave.

15 MAR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 24, 1924, that I last saw her alive on March 24, 1924, and that death occurred, on the date stated above, at 5.50 P.m.

The CAUSE OF DEATH* was as follows:

apoplexy

Carcinoma of Uterus (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

Complications of Disease (duration) yrs. 4 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr Gil Kennard M. D.

3-25 1924 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: Mar 27 1924

20 UNDERTAKER: Wm R. G. Elliott — ADDRESS: 1725 Eastland.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85302

CERTIFICATE OF DEATH.

188-003 D 85302

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Osugo & Parkwood WARD)

2-FULL NAME. Frederick Branham Green

(a) RESIDENCE No. 2628 Oswego Ave ST., ... WARD .....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Clarence R Green

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Florence E Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Clarence R Green
(Address) 2628 Oswego Ave

15 Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

THE CAUSE OF DEATH* was as follows: Injuries on Auto Accident accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J Mooney, M. D.
(Coroner.)
Mar 26 1924 (Address) 30 E Redwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetary

DATE OF BURIAL 3/28 1924

20 UNDERTAKER William Cook

ADDRESS 502 E Nork

N. B.—MARRIAGE, BIRTH AND DEATH CERTIFICATES, WITH CERTIFIED COPIES OF THE RECORD, EACH, may be obtained at the Bureau of Vital Statistics, Room 105, City Hall. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Beachum

110319 Mar 2-85303

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 85303

CERTIFICATE OF DEATH. 38

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME William Beachum

(a) RESIDENCE NO. 2204 Essex ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Not Known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Beachum

6 DATE OF BIRTH (month, day, and year) Feb 24, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	— 1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roofer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Simons Gorfold Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL. ~~ROBERT P. KRAUTER~~

15 MAR 27 1924 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1924, to Mar 25, 1924, that I last saw h alive on Mar 25, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pan-Syphilis

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Empyema + Peritonitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Aug Jacobsky, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Woodlawn	Mar 28 1924

20 UNDERTAKER Wm Cook ADDRESS 502E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 35304

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Phillip M. Golden

(a) RESIDENCE NO. 629 W Arlington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Charlotte Golden

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

042

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Hoffman

(Address) 2805 Eldorado Ave

15 Filed MAR 27 1924 ROBERT F. KRAUSE Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 25, 1924, that I last saw him alive on March 25, 1924 and that death occurred, on the date stated above, at 11.25 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Partial

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Tompkins M. D.

, 19 (Address) 1 Mt Vernon Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 28, 1924
20 UNDERTAKER	ADDRESS
Wm. Cook for E. Mosher	

Cor.—1-12-23—M&T—100 Bks.

Dr. Morrissey

D 85305 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85305

74 L 24

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1510 Kinsett St. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Ashley.

(a) RESIDENCE NO. 1510 Kinsett ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 21, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	43	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Vincent Ashley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Adams

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Charles Schmitz
(Address) Clinton, Md.

15 Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar
Social Security Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Morrissey M. D.
(Coroner.)

Mar 26, 1924 (Address) 5692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 3/27 1924

20 UNDERTAKER William Cook

ADDRESS 502 E North

N. B.—WRITE LEGIBLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should strike CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85306

CERTIFICATE OF DEATH.

1-3 D 85306

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 N. Amm ST., 6 WARD)

2-FULL NAME alice a Jamette

(a) RESIDENCE NO. 408 N Amm ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallace R. Jamette

6 DATE OF BIRTH (month, day, and year) June 2/54

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housew 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Howard R Jamette (Address) 1703 Aisquith St

15 Filed 19 ROBERT E. KRAUSE Registrar

MAR 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1924, to Mar 24, 1924.

that I last saw h alive on Mar 24, 1924

and that death occurred, on the date stated above, at 11-P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

Mar 26 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem -	3/27 1924
20 UNDERTAKER Philip Herring	ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 85307

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 N. Castle St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie R. Strohl

(a) Residence No... 503 N. Castle St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred W. Strohl

6-DATE OF BIRTH (month, day and year): Dec 16/82

7-AGE: 41 yrs. 3 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Nicholas Lotz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Elizabeth —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant): Fred. W. Strohl

(Address): 503 N. Castle St.

15-

Filed MAR 27 1924 ROBT. P. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3/24/24

I HEREBY CERTIFY, That I attended deceased from 2-1— to 3-24 to 3-24 19 24

that I last saw h[illegible] alive on 3-23 19 24

and that death occurred, on the date stated above, at 11:30 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia
Acute Toxemia
Acute Endocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Schmidt M. D.

19 24 (Address) 502 N. Castle St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: 3/28 19 24

20-UNDERTAKER: Philip Herring — ADDRESS 2016 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. EVERY ITEM UNDER THIS HEADING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 85308

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 S. Fremont Ave ST., 21 WARD)

2-FULL NAME Dorothy C. Meyers

(a) RESIDENCE NO. 913 S. Fremont Ave ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 14 1906

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
17	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer) C. P. Tel. Co.

(c) Name of employer Plaza Exchange

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emelia Meier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Frederick Meyers
(Address) 913 S Fremont Ave

15 Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-1924

17

I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1923 to March 24, 1924.

that I last saw her alive on March 24, 1924,

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 4 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 3-28-1924

20 UNDERTAKER E. B. Steele — ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85309 — 31 D 85309

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Sterling ST., 5 WARD)

2-FULL NAME Charles Cleary

(a) RESIDENCE NO. 627 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	~~11~~ 1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work labor 060

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer warner clery

9 BIRTHPLACE (city or town) (State or country) white plain va

PARENTS

10 NAME OF FATHER warner clery

11 BIRTHPLACE OF FATHER (city or town) (State or country) white plain va

12 MAIDEN NAME OF MOTHER agnes smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) va.

14 Informant (Address) florence clery 627 steerling st.

MAR 27 1924

ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from February 1924, to March 25 1924,

that I last saw h alive on March 25 1924,

and that death occurred, on the date stated above, at 5:05 P. m.

The CAUSE OF DEATH* was as follows: Acute Anemia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Bryan, M. D.

, 19 (Address) 607 N. Eu

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL mt zion cemetery

DATE OF BURIAL 29 march 1924

20 UNDERTAKER Edward Bryan

ADDRESS 631 orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.P.S.—400 Bks.

D 85310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85310

CERTIFICATE OF DEATH.

161-00

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1701 Jefferson St St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Reuschling

(a) Residence No. 1701 Jefferson St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6-DATE OF BIRTH (month, day and year): Mar 26/24

7-AGE: 3 hrs yrs. 31/2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Wm. Joseph Reuschling

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Margaret M. Martin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14- (Informant): Wm. J. Reuschlng

(Address): 1701 Jefferdon St

15- Filed MAR 27 1924 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-26-24

17- I HEREBY CERTIFY, That I attended deceased from Mar 26/24 19.. to Mar 26/24 19.. that I last saw him alive on Mar 26/24 19.. and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Inanition- Premature Birth

(7 1/2 mons. gestation)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J S H Collen M. D

Mar 26/24 (Address) 508 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 29 19 24
20-UNDERTAKER.	ADDRESS
Richard H Kenby	110 S Guilford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85311

CERTIFICATE OF DEATH.

731

D 85311

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Phillips

(a) Residence No. Catonsville Manor St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (~~Write~~ the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) Nov. 15, 1862

7-AGE. 61 yrs. 4 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

11-Informant Mrs Barbara Weller

(Address) Catonsville Manor

MAR 27 1924

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25 24

17-I HEREBY CERTIFY, That I attended deceased from June March 25 24 to March 25 24

That I last saw h.. alive on March 25 24

and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc
Myocardial insufficiency
with Anasarca

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cystitis - Bedsores

(Duration) 3 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab + Phys Idg

(Signed) H. O Harper M. D

19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cemetery	Mar 28, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sanders & Sons	1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.—400 Bks.

D 85312

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 85312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 15 Willax Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina E. Poetter

(a) Residence No. 15 Willax Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick W. Poetter

6-DATE OF BIRTH (month, day and year) Jan 27, 1844

7-AGE, 80 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Heinrich Kraemer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Not Known

14- (Informant) Miss Elizabeth Poetter

(Address) 15 Willax Ave

15-

Filed..... 192 ROBERT N. KRAUTER, Registrar.

MAR 27 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 26/24

17- I HEREBY CERTIFY, That I attended deceased from March 17th 1924 to March 25th 1924, that I last saw her alive on March 25/24 1924, and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Myocardium

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia V Zimmerman M. D

19 (Address) 1805 W North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Pauls Cemetery	Mar 29, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander & Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85313

CERTIFICATE OF DEATH.

90

D 85313

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Carter Ave Raspeburg 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Glenn

(a) Residence No. Carter Ave Raspeburg Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Glenn

6-DATE OF BIRTH (month, day and year) Oct 12 1840

7-AGE.	If LESS than 1 day.
83 yrs. 5 mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown Waggner

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Unknown

14- (Informant) Mrs Wm H. Carter

(Address) Carter Ave Raspeburg

15- Filed MAR 27 1924 192 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 26 1923 to March 26 1924

that I last saw h.. alive on March 25. 1924

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) E. L. Pearson M. D

3.26. 1924 (Address) Glen Riddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	Mar. 28. 1924
20-UNDERTAKER.	**ADDRESS**
H. Sanders & Sons	1710 Fleet St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

107 D 85314

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Taylor

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1857

7-AGE. 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Maryland
(State or Country),

PARENTS.

10-NAME OF FATHER, Bob Taylor

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 27 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-22-24

17- I HEREBY CERTIFY, That I attended deceased from 3-13 1924 to 3-22 1924

that I last saw b alive on 3-21 1924

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Non-Tuberculous Pulmonary Inspection

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Bruce M. D.

3-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL-	DATE OF BURIAL.
Bonnie Brae	March 27, 1924
20-UNDERTAKER.	ADDRESS
Mrs R. A. Elliott	1725 Holland ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ B 85315

B 85315

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1612 Oliver ST. 23 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J Ruthell.

(a) RESIDENCE. No. 1612 Oliver ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) ~~WIFE~~ of Jno R Ruthell

6 DATE OF BIRTH (month, day, and year) Dec. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Wm. J. Ruthell

(Address) 1612 Oliver St.

15 MAR 27 1924 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1924 to Mar 24, 1924

that I last saw her alive on Mar 24, 1924

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) R. L. Campbell, M. D.

Mar 26, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	3/27/1924

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1460 Battery Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85316

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 26 East 25th. St., 12 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Albert Broadbelt, Jr.

(a) Residence No. 26 East 25th. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Malambre

6-DATE OF BIRTH (month, day and year) Aug. 19, 1870

7-AGE.	If LESS than 1 day.
53 yrs. 7 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Machinist

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Beale Valve Co.

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore Co., Md

PARENTS.

10-NAME OF FATHER. Henry A. Broadbelt

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Penn.

12-MAIDEN NAME OF MOTHER. Hannah Kitson

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). England

11- (Informant) Mrs. Bertie Broadbelt

(Address) 26 East 25th. St.

15- Filed MAR 27 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-25-24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1924 to Mar 25, 1924

that I last saw h.~~im~~ alive on Mar 24, 1924

and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Chron Endo Carditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. O'Hara M. D

3-26, 1924 (Address) 5600 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	Mar 28, 1924 19....

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

WRITE PLAINLY, WITH UNFADING INK—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85317

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Clinton & Bayley St., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel D. Williams

(a) RESIDENCE NO. 1109 S. Clinton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Williams

6 DATE OF BIRTH (month, day, and year) Aug. 22-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 140
(b) General nature of industry, business, or establishment in which employed (or employer) Palace Bar.
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Margaret Williams
(Address) 1109 S. Clinton St.

15 Filed ..... 192 Robert P. Harrison,
Registrar
Burial Permit Clerk

MAR 27 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Blodel, M. D.
(Coroner)

3-26-24 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL Mch 29 1924

20 UNDERTAKER Zilly and Zeiler

ADDRESS 1031 Monroe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85318

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85318

CERTIFICATE OF DEATH.

1924

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. Homewood Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret L. Hughes

(Residence in Baltimore: No. 923 N. 10th St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: July (Month) 13 (Day) 1893 (Year)

7-AGE: 30 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 37

9-BIRTHPLACE, (State or Country): Balto Co Md

PARENTS.

10-NAME OF FATHER: R. Leyshon

11-BIRTHPLACE OF FATHER, (State or Country): Wales

12-MAIDEN NAME OF MOTHER: M Ward

13-BIRTHPLACE OF MOTHER, (State or Country): Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Hughes

(Address) 923 N. 10th St

15-

MAR 27 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 25 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia following Ill. Abortion

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) John Morrison M. D. (Coroner.)

Mar 27 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Mch 28 1924

20-UNDERTAKER: Lilly Zeiler — ADDRESS: 403 S. Wolfe St.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85319

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 85319

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1908 McElderry St., ... St., 7 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mildred Marks .....

(a) Residence No. 1908 McElderry ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 8th-23

7-AGE. ..... yrs. 9 mos. 19 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto., Md

PARENTS.

10-NAME OF FATHER. Soloman Marks

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rose Katz

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Russia

14- (Informant) Soloman Marks

(Address) 1908 McElderry St.,

15- Filed MAR 27 1924 192 Robert P. Harrison, Registrar.

Buried Ferrett Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-27-24

17- I HEREBY CERTIFY, That I attended deceased from March 26 1924 to March 27 1924

that I last saw h-r alive on March 27 19 24

and that death occurred, on the date stated above, at 8.45AM m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

Acute Toxic Ileus (Duration) ..... yrs. mos. 12 hrs

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Arrest of Conduction

(Signed) B. Bluestone M. D.

, 19 (Address) 131 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Workmen Circle, Hebrew Mt. Carmel

DATE OF BURIAL, 3-27-24

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 E. Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85320

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

2-FULL NAME Mrs. Sarah Snyder

(a) RESIDENCE NO. 3604 Eastern Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND OF~~ (or) WIFE of Mr. William Snyder.

6 DATE OF BIRTH (month, day, and year) March 26 - 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	~~28~~	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Frederick W. Wiest.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Sarah Spotts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant William H. Snyder.
(Address) 3604 Eastern Ave.

15 Robert P. Harrison, Registrar

MAR 27 1924

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 25, 1924,
that I last saw he alive on March 25, 1924,
and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Pelvic peritonitis. (over)

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency ?
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Mar. 11, 1924

Was there an autopsy? .....

What test confirmed diagnosis? Clinical findings & Gross

(Signed) Physician Pamellee, M. D.

, 19 (Address) Church Home and Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Valley Penn.

DATE OF BURIAL March 29 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85321 HEALTH DEPARTMENT—CITY OF BALTIMORE. D 85321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 S. 13th St ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Slawski

(a) RESIDENCE. NO. 516 S. 13th St ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs — mos. — ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Slawski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Petronella Cyziewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Wroblewski (Address) 516 S 13-24

Filed MAR 27 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to March 26, 1924, that I last saw him alive on March 26, 1924, and that death occurred, on the date stated above, at 3.20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & Symptoms

(Signed) John V. Szerbicki, M. D.

(Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Mar 28 1924
20 UNDERTAKER	ADDRESS
Stephen L Fralkowski	100 S Ponca St

WRITE PLAINLY. WHEN ONE WORD OR FIGURE IS ERASED OR CHANGED, THE PERSON MAKING THE CHANGE MUST WRITE HIS INITIALS IN THE MARGIN. All information should be stated EXACTLY. PHYSICIANS should be careful to see that AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH is properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH is properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH is properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificates. THIS IS very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85322

99-902 ✓ D 85322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Hanover St. ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Jerome Williams.

(a) RESIDENCE NO 1906 Hanover St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. -- mos.-- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary E. Williams.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	--	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Crossing watchman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A.A.Co Md.

PARENTS

10 NAME OF FATHER Alfred Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A.Co Md.

12 MAIDEN NAME OF MOTHER Dulany ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A.A.Co Md.

14 Informant Mary E. Williams. (wife)
(Address) 1906 Hanover Street.

15 Filed MAR 27 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.
Acute dilatation of the heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)
March 27, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL March 28 1924

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ACCU-RATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

David S. Mitchell

D 85323

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓

74 D 85323

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3435 Greenmount St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... David S Mitchell

(a) Residence No. 3435 Greenmount St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of: Anna Mitchell

6-DATE OF BIRTH (month, day and year): Nov 10, 1857

7-AGE: 66 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: merchant X

(b) General nature of industry, business, or establishment in which employed (or employer): 0 4 5

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country): Calvary, md

PARENTS.

10-NAME OF FATHER: Franklin Mitchell

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country): unknown

12-MAIDEN NAME OF MOTHER: — Hawkins

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country): unknown

14- (Informant): David B Mitchell

(Address): 725-13th St N.W. Washington D.C.

15- Filed MAR 27 1924 [illegible] Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 26/24

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to March 26 1924

that I last saw him alive on March 26 1924

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) ..... yrs. 4 mos. ..... ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John S. Fraley M. D

3/27 1924 (Address) 3522 Greenmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — DATE OF BURIAL: March 28 1924

20-UNDERTAKER: Trafford Co Inc — ADDRESS: Edw Cook Fayette & Monroe Sts

N. B.—WRITE PLAINLY WITH INK. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85324

CERTIFICATE OF DEATH.

11-007

D 85324

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Holly St., 27 WARD)

REGISTERED NO. 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo F. Waldejo

(a) RESIDENCE NO. 10 Holly St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	M.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie S. Farrell.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

026

9 BIRTHPLACE (city or town) (State or country) Paris France.

PARENTS

10 NAME OF FATHER Leo Waldejo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Paris, France

12 MAIDEN NAME OF MOTHER Virginia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Paris France.

14 Informant Annie S. Farrell. (Address) 10 Holly St.

15 Filed MAR 27 1924, Robert P. Harrison, Registrar

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to March 24, 1924, that I last saw him alive on March 24, 1924, and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Eshenbrack, M. D.

March 27, 1924 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem

DATE OF BURIAL 3/28 1924

UNDERTAKER J. J. Fahey Sons

ADDRESS 131 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 85325

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1647 N. Milton Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John C. Caspare

(a) Residence No. 1647 N. Milton ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed,~~ or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE~~ of Dora E Caspare

6-DATE OF BIRTH (month, day and year) Feb 25-1899

7-AGE, 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank C Caspare

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Kate Panch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto md

14- (Informant) Lloyd E Caspare

(Address) 1647 N milton ave

15- MAR 28 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 25 1924

17- I HEREBY CERTIFY, That I attended deceased from about January 1922 to 3-25-1924 that I last saw h. alive on 3-25-1924 and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Renal arteriosclerosis with hypertension

(Duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine blood tests

(Signed) J. A. Duncan C. M. D.

3-27, 1924 (Address) 1004 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL, March 28 1924

20-UNDERTAKER Robt J Turner Sr — ADDRESS 1242 N Broadway

N. B.—WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85326

CERTIFICATE OF DEATH.

D 85326

1-PLACE OF DEATH

City of BALTIMORE: (No. 1624 N. Bradford St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Kearney

(a) Residence No. 1624 N. Bradford St

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. — mos. — ds. How long in U. S., if of foreign birth? 83 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND (or) WIFE of the late Charles Kearney

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 83 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... ods

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward Collison

11-BIRTHPLACE OF FATHER (city or town) England (State or Country),

12-MAIDEN NAME OF MOTHER, Sally Lynch

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country),

14- (Informant) Mr. Joseph Heffernan

(Address) 1624 N. Bradford St

15- Filed MAR 28 1924, 19.. ROBERT R. KRAUTER, Registrar.

No. ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 19 24 to March 27 19 24

that I last saw her alive on March 26 19 24

and that death occurred, on the date stated above, at 11.10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) B P Herzog M.D. M. D

Mar 27, 1924 (Address) 1305 N Patterson Pk Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Vincents Cemetery

DATE OF BURIAL. March 29, 19 24

20-UNDERTAKER. Henry Stock Son

ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85327

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Mc Henry ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond A. Carle

(a) RESIDENCE NO. 1312 Mc Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/12/97

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Patrick J. Carle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Anna Lombard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Anna Carle
(Address) 1312 McHenry St

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/26, 19 24, to 3/26, 19 24,

that I last saw h alive on 3/26/24, 19

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Lob. Pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Raymond Stern, M. D.

3/27, 19 24 (Address) 710 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Mar 28 19 24

20 UNDERTAKER John J. Fields

ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85328 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 74 b 85328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Babb

(a) RESIDENCE NO. 1514 School ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25-192X

17

I HEREBY CERTIFY, That I attended deceased from 1-24, 1922 to 3-25, 192X,

that I last saw him alive on 3-25, 192X,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension

Right Hemiplegia (Cerebral Hemorrhage)

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude B. Heaver, M. D.

3-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mch 28 1924
20 UNDERTAKER	ADDRESS
Carl N. Chase Sons	400 W Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85329

CERTIFICATE OF DEATH.

16-001

D 85329

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 633 Archer St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Baby Turner

(a) Residence No.... 633 Archer St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 26 '24

7-AGE. ... yrs. ... mos. ... ds.

If LESS than 1 day. 18 hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Walter Turner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary L. Ringgold

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Walter Turner

(Address) 633 Archer St

15- MAR 28 1924 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 27 '24

17- I HEREBY CERTIFY, That I attended deceased from Mar 26, 1924, to Mar 27, 1924, that I last saw h[illegible] alive on Mar 26, 1924, and that death occurred, on the date stated above, at 3 A. p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Seven months)
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. Hanzell, M. D.

3/27, 1924 (Address) 1400 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel St — DATE OF BURIAL, March 28, 1924

20-UNDERTAKER, I. L. Brownson — ADDRESS 1811 Mont'g St

EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACT in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X/18 002 D 85330

CERTIFICATE OF DEATH.

85330

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U S Marine Hospital St., V WARD)

2-FULL NAME Harry Edwards

(a) RESIDENCE NO. U S Marine Hospital No 1 ST., WARD

(Usual place of abode) Baltimore Md

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman O66

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer U/s Chester Sun

9 BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self

(Address)

15 MAR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1924, to March 25, 1924, that I last saw him alive on March 25, 1924, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Paralytic Illeus following intestinal resection for stricture.

(duration) yrs 1 mos 18 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Feb 6, 1924

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. Foster. M. D.

19 (Address) U.S. Marine Hospital No 1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Mar 28 1924

20 UNDERTAKER Sol Simson & Bro

ADDRESS 102 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 85331

CERTIFICATE OF DEATH.

D 85331

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Daisy Brelsford

(a) Residence No. 2617 Dulaney Pl St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Curtis Brelsford

6-DATE OF BIRTH (month, day and year) June 20 1887

7-AGE. 36 yrs. 9 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED.
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Jones Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Ella Newton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14-Informant Curtis Brelsford

(Address) 2617 Dulaney Pl

15-

Filed ..... 192 ROBERT R. KRAUTER

MAR 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 26-24

17-I HEREBY CERTIFY, That I attended deceased from March 12 19 24 to March 26 19 24

That I last saw h-e alive on March 26 19 24

That death occurred, on the date stated above, at 9 12 am

The CAUSE OF DEATH* was as follows:

Acute Superior Poliocencephalitis

(Duration) ..... yrs. ..... mos. 26 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Lumbar Puncture

(Signed) Dr Goldman M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/28/24
20-UNDERTAKER.	ADDRESS
J B Keyser	1236 Fed'l Av

N. B.—WRITE PLAINLY, with unfading ink. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 85332

CERTIFICATE OF DEATH.

161-001

B 85332

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Jefferson St ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Reuschling

(Residence in Baltimore: No. 1701 Jefferson St St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.)
male	white	single

6-DATE OF BIRTH, ... Mar 26/24 ....., 1 .....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 1 ds.	....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto.Md

PARENTS.

10-NAME OF FATHER, Wm. J. Reuschling

11-BIRTHPLACE OF FATHER (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Margaret M[illegible] Martin

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J? Reuschling

(Address) 1701 Jefferson St

MAR 28 1924

Filed ....., 191....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... March 27/24 ....., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 26/24 191..., to Mar 27/24 191...,
that I saw h im alive on Mar 27/24 191...,
and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Prematurity- 7 1/2 mons. gestation

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J S Hollan M. D.

Mar 27/24 191... (Address) 508 E. NOrth Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	March 28, 1924
20-UNDERTAKER	ADDRESS
Richard F. Cuzley	1108 Gen Yard Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

85333

HEALTH DEPARTMENT—CITY OF BALTIMORE

85333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bowley's Lane near Philadelphia Road St., No. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Eleanora Langenfelder

(a) RESIDENCE NO. Bowley's Lane, near Philadelphia Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	At School

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 29th 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Langenfelder

11 BIRTHPLACE OF FATHER (city or town) Balto Co.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth W. Kindick

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Henry Langenfelder
(Address) Bowley's Lane near Phila Rd

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1924, to Mar 26, 1924

that I last saw her alive on Mar 26, 1924

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Rheumatism

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Place of dead-

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Frank Long, M. D.

(Address) 27 N. Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Lutheran Cemetery	March 30 24
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33 rd ST., 12 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. [redacted] Weiner

(a) RESIDENCE No. 5016 Outhwaite Ave, Cleveland, Ohio ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? 20 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isador Weiner

6 DATE OF BIRTH (month, day, and year) Nov. 1. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Jacob Blumberg

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Mankin

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Patient
(Address) .....

15 MAR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to March 27, 1924, that I last saw her alive on March 27, 1924, and that death occurred, on the date stated above, at 8.05 P m.

The CAUSE OF DEATH* was as follows:

Exophthalmic goitre

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? Cleveland, Ohio

Did an operation precede death? Yes Date of March 27, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald Chandler, M. D.

3/27 1924 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cleveland Ohio	3-28 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E 55th

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85335

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1609 Eutaw Place St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lettie A. S. Mattingly

(a) Residence No. 1609 Eutaw Place Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Jos H Mattingly

6-DATE OF BIRTH (month, day and year) Aug 8 1838.

7-AGE, 85 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Basil Jarboe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Anna Haden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Geo Mattingly

(Address) 1609 Eutaw Place

15- Filed MAR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 27/24

17- I HEREBY CERTIFY, That I attended deceased from July 1924 to Mch. 27 1924 that I last saw h[er] alive on Mch 27th 1924 and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Old age

About 1 yrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank Glover M. D.

, 19 (Address) 1500 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Marganza Maryland | DATE OF BURIAL, Mar 29, 1924

20-UNDERTAKER, Josiah Iffes | ADDRESS 1600 N. North Ave

N. B.—WRITE PLAINLY, WITH INK. ALL ITEMS in this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85336 — 11 4 — D 85336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1607 Friendship ST., 15 WARD)

2-FULL NAME Alice R. Chastain

(a) RESIDENCE NO. 1607 Friendship ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jesse J. Chastain

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	30	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Evelina Strait

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jesse J. Chastain
(Address) 1607 Friendship Av.

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(duration) 3 days

CONTRIBUTORY (Secondary) acute dilatation of heart, 15 minutes

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hennessy, M. D.
(Coroner.)

March 27, 1924 (Address) 702 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Mar 29 1924

20 UNDERTAKER Josiah Lyser — ADDRESS 1600 or North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Ekr.

(Gruszynski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85337 — D 85337

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Gruszynski

(a) Residence No. 623 Wolfe Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Young Gruszynski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) F. Polek

(Address) 416 St. Stret & Eastern ave

15- MAR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/27/24

17. I HEREBY CERTIFY, That I attended deceased from January 24 19 24 to March 27 19 24

that I last saw her alive on March 27 19 24

and that death occurred, on the date stated above, at 6-20 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma — Cervix —

General Metastasis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. F. Fallon M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St. Stanislaus	March 29 1924
20-UNDERTAKER.	**ADDRESS**
M. F. Sadowski	905 S. Ann St.

N. B.—WHITE PEARL, WHITE UNRULED PAPER. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See should be stated in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85338

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Bank ST.: W WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lafant Kendzerski

(a) RESIDENCE. NO. 1917 B Bank ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 19-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Kendzerski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Kolenicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Frank Kendzerski (Address) 1917 Bank

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to March 28, 1924, that I last saw h[illegible] alive on March 28, 1924, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Acta lactosa

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Reysack M. D.

Mar 28/24 (Address) 801 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	March 28 1924

20 UNDERTAKER J. W. Ozarowski ADDRESS 1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85339

CERTIFICATE OF DEATH.

31 ✓

D 85339

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elizabeth Hill

(a) Residence No.... 626 N. Bond Street St.,.... Ward....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4-10-902

7-AGE.	If LESS than 1 day.
22 yrs. mos. ds.	hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housemaid

(b) General nature of Industry, business, or establishment in which employed (or employer)... 070

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Alex. Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Matilda

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Viola Hill

(Address) 626 N. Bond St.

15-

Filed 192

MAR 28 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/26/24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 13 1924 to March 26 1924, that I last saw h.er alive on March 26 1924, and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Pulmonary

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) T.B - Skin - Right Shoulder

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M. J. Fulton M. D.

19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
West Point Va.	March 28 1924
20-UNDERTAKER.	ADDRESS
Wm J. G. Locks	1312 Jefferson

R. S.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85340

CERTIFICATE OF DEATH.

31

D 85340

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3921 E. Monument St.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony Lewis Miller

(Residence in Baltimore: No. 3621 E. Monument St.; Life mos. ds)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: Dec. 31, 1902 (Month) (Day) (Year)

7-AGE: 21 yrs. 2 mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or partieular kind of work: Gone
(b) General nature of industry, business, or establishment in whieh employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Geo. Joseph Miller

11-BIRTHPLACE OF FATHER (State or Country): Balto. Md.

12-MAIDEN NAME OF MOTHER: Elizabeth B. Ott

13-BIRTHPLACE OF MOTHER (State or Country): Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph L. Miller

(Address) 1623 E. Fratt. St.

15- MAR 28 1924

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 26 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3-1 1924 to 3-26 1924, that I saw h[illegible] alive on 3-25 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(Duration) yrs. 3 mos. ds.

(Signed) Fred Rupp Jr. M. D.

26, 1924 (Address) E. N. Y. Ave. Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer — DATE OF BURIAL, Mar. 29, 1924

20-UNDERTAKER: George L. Schwab — ADDRESS 2101 Eutaw Ave.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85341

CERTIFICATE OF DEATH.

129 ✓ D 85341

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 McHenry St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline E. Eisenhardt,

(Residence in Baltimore: No. 2012 McHenry St St.: 65 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widowed

6-DATE OF BIRTH, July 24, 1850 (Month) (Day) (Year)

7-AGE, 73 yrs. 8 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Lohr

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amalia Smithen

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. George Miller

(Address) 2012 W. McHenry St.

15- MAR 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to Mar. 25, 1924, that I saw her alive on March 25, 1924 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis,

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) J. Thos. Norton M. D.

3/27/1924 (Address) 888 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery DATE OF BURIAL, Mar. 28, 1924

20-UNDERTAKER George L. Schwab ADDRESS 2101 Eutaw Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85342

CERTIFICATE OF DEATH.

146 D 85342

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 N. Exeter Street ST., 5 WARD)

2-FULL NAME Sadie Pistorio

(a) RESIDENCE NO. 307 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tony Pistorio

6 DATE OF BIRTH (month, day, and year) 2/1/1896

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
28	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Tarmino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Silvestre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Margaret Fules

(Address) 3017 N Exeter St

15 MAR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/22, 1924, to 3/27, 1924,

that I last saw h[illegible] alive on 3/26 1924

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Phys Examination

(Signed) Henry G. Malone, M. D.

3/27 1924 (Address) 2210 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 3/29 1924

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85343

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 85343

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2916 Weaver Ave ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carl Krahn

(a) RESIDENCE NO. 2916 Weaver Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Freade Krahn

6 DATE OF BIRTH (month, day, and year) Nov 26/1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	~~74~~ 74	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant August Krahn
(Address) 2916 Weaver Ave

15 Filed MAR 28 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (RT)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Ford Walter, M. D.
(Coroner.)

March 26/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 3/28 1924

20 UNDERTAKER George F. Ruth — ADDRESS 1735 Hanford Av

HEALTH SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85344

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — REGISTERED NO. C 188

CITY OF BALTIMORE (No. Mount Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ernest August Prigge

(Residence in Baltimore: No. Mount Hope Retreat. 34 Years St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, Dec 21, 1856 (Month) (Day) (Year)

7-AGE, 68 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer): Laying brick

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Fritz Prigge

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Rosalie Domire

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Flannery M.D.

(Address) Mt Hope Retreat

15-

Filed MAR 28 1924 191. ROBERT R. KRAUTER.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 27, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull, (accidental). Fell off of coal car, while unloading at [illegible]

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chr. Mania - Pot Alcoholism

(Duration) 34 yrs. 0 mos. 0 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

March 27 1924 (Address) 280 Reedsdale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 34 yrs. 0 mos. 0 ds. In the State 34 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Mt Hope Retreat Baltimore

Former or usual residence Mt Hope Retreat

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery — DATE OF BURIAL, March 28, 19..

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85345

D 85345

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 919 Vincent St., 16 WARD)

2-FULL NAME Mrs. Mollie Miller

(a) RESIDENCE NO. 919 Vincent St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Miller

6 DATE OF BIRTH (month, day, and year) about 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) Georgia
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas. T. Miller
(Address) 919 Vincent St.

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. C. Hennessy M. D.
(Coroner)

March 27 1924 (Address) 210 N. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	March 28 1924
20 UNDERTAKER Jessup Peckham	ADDRESS W. Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85346

CERTIFICATE OF DEATH.

D 85346

5-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Benjamin Jones

(a) Residence No. Reisterstown Rd + Glyndon Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1839

7-AGE. 85 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Wm Jones

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address).....

MAR 28 1924

ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk.

1365

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-24-24

17- I HEREBY CERTIFY, That I attended deceased from 3-19, 1924, to 3-24, 1924, that I last saw him alive on 3-24, 1924, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows.

Arteriosclerosis

Left Hemiplegia (Hemorrhage)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Brace M. D.

3-25-, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. MAR 28 1924 19....
20-UNDERTAKER. Commissioner Health.	ADDRESS

Per. Wm. E. [illegible]

UNIVERSITY OF MARYLAND.

98

N. B.—WHITE PENCIL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85347

CERTIFICATE OF DEATH.

34 D 85347

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 ST., Bay View Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Hyer

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unkn.

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) D. C.
(State or country)

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) Do
(State or country)

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) Do
(State or country)

14 Informant Bay View Hospital
(Address)

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to March 26, 1924.

that I last saw him alive on March 25, 1924,

and that death occurred, on the date stated above, at 4.55 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis
Luetic Infection

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Tbc.

Unkn. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) H. Goldsmith, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND, Commissioner of Health. MAR 25 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should be careful and prompt in filling out certificates. Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION of deceased is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85348

CERTIFICATE OF DEATH.

57

D 85348

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Brentwood ST., 16 WARD)

2-FULL NAME Amalie Bena Aetz

(a) RESIDENCE NO. 3006 Brentwood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jean B. Aetz

6 DATE OF BIRTH (month, day, and year) Nov 7 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 037

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) St. Quirin France

PARENTS

10 NAME OF FATHER August Bena

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Quirin France

12 MAIDEN NAME OF MOTHER Amalie Jaxel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Quirin France

14 Informant Louis D. Aetz (Address) 7912 Riggs Rd

15 Filed MAR 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1924, to Mar 27, 1924, that I last saw her alive on Mar 27, 1924 and that death occurred, on the date stated above, at 120 m.

The CAUSE OF DEATH* was as follows:

Right Sided Hemiplegia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place Death ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Obvious Exam

(Signed) John A. Hufford (M. D.)

3/28 1924 (Address) 1219 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Naval Cemetery Annapolis Md — DATE OF BURIAL Mar 28 1924

20 UNDERTAKER C L Hoffberg — ADDRESS Annapolis Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85349

CERTIFICATE OF DEATH.

1893 ✓ 188-09

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Ridgely & Bayard Sts. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert N. Gubernatis.

(a) RESIDENCE NO 1108 S. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) April 6, 1914.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	9	11	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Gubernatis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cecelia Von Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Peter Gubernatis (father)
(Address) 1108 S. Paca Street.

15 Received MAR 28 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and laceration of the brain, struck by an automobile. Accidental death.

(duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) (duration) .... yrs. .... mos. .... ds.

(Signed) Otto Reinhardt M. D. (Coroner.)

March 28. 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 3/29 1924

20 UNDERTAKER Jas Duggan Son — ADDRESS 1000 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85350

CERTIFICATE OF DEATH.

D 85350

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 319 W. Biddle St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Jenifer

(a) Residence No. 319 W. Biddle St.,

(Usual place of abode) Ward

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 1865

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, Geo. Jenifer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), md

12-MAIDEN NAME OF MOTHER, Adeline Matthews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), md

14-

(Informant) Joseph Jenifer

(Address) 319 W. Biddle

15-

Filed MAR 28 1924, 19?

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 27/24

17- I HEREBY CERTIFY, That I attended deceased from Mar 1, 1924, to Mar 26, 1924, that I last saw him alive on Mar 26, 19..., and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam,

(Signed) Paul Gillaspie M. D.

3/27/1924 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Waldorf, Charles Co Md — DATE OF BURIAL, 3-29-1924

20-UNDERTAKER, John H. Toadvine — ADDRESS 142 Druid Hill Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85351

CERTIFICATE OF DEATH.

111-001 ✓ D 85351

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 Sharp St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Handy James

(a) Residence No. 1104 Sharp St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Arrie James

6-DATE OF BIRTH (month, day and year) Unk 1872

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Georgia

PARENTS.

10-NAME OF FATHER. Peter James

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ga

12-MAIDEN NAME OF MOTHER. Hattie —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Georgia

14- (Informant) Arrie James

(Address) 1104 Sharp St

15- Robert P. Harrison, Registrar.

Filed ....., 192.....

MAR 28 1924 ~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 26. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 22 19 24 to March 26 19 24

that I last saw h. m. alive on March 26 19 24

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

3/27, 1924 (Signed) H S M Card M. D.
(Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn — DATE OF BURIAL. 3.30.., 1924

20-UNDERTAKER. John H. Joadim — ADDRESS 142 Ostend St

WHITE ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85352

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 ✓ D 85352

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 S Eutaw ST., 21 WARD)

2-FULL NAME William Webster

(a) RESIDENCE No. 1008 S Eutaw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Webster

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Helper Painting

(c) Name of employer S. Ober & Son

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Oscar Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Caroline Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Theo. Williams

(Address) 16 W Hamilton St

15 Received MAR 28 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1924, to 3/26, 1924, that I last saw h[im] alive on 3/26, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia (duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) J Guy Bowley M. D.

3/27, 1924 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3-29 1924
20 UNDERTAKER	ADDRESS 142
John H. Toadvine	Mosher St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85353

D 85353

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 Mynlli ST. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice B. Brown

(a) RESIDENCE. NO. 1301 Mynlli ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colrd	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Johns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Emory Bonds

(Address) 1308 Hopkins Ave

15 Filed MAR 28 1924 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1924, to March 26 1924, that I last saw h[illegible] alive on March 26 1924 and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows: Cardiac Disease Collapse

(duration) yrs. — mos. 22 ds.

CONTRIBUTORY (Secondary) Do Pneumonia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) Thomas A Ford M. D.

(Address) 714 S Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3-29 1924
20 UNDERTAKER	ADDRESS 142
John H. Tongue	Ostend St

THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85354 D 85354

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121½ McCulloh ST. 14 WARD)

2-FULL NAME John H. Bundy,

(a) RESIDENCE NO. 2121½ McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preaching

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Virginia
(State or country)

PARENTS

10 NAME OF FATHER Wm Bundy

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant (Address) James H Bundy

MAR 28 1924 Filed, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26- 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-9-, 1923, to 3-26-, 1923, that I last saw h— alive on 3-26-, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Prostatitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary test

(Signed) Wm. H. Cargill, M. D.

3-28-1924 (Address) 611—N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C

DATE OF BURIAL 3-29 1924

ADDRESS 142 Ustick St

20 UNDERTAKER John H. Jordan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 85355 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 85355

X74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. William & York Sts. ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Hazzard. (C)

(a) RESIDENCE No 712 S. 19th. St. Philadelphia, Pa. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred None. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced
HUSBAND OF ~~XXXXXXXXXXXX~~
~~XXXXXXXXXX~~ Luberta Hazzard. (C)

6 DATE OF BIRTH (month, day, and year) Do not. know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steward.
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Norfolk, Clyde Line
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Luberta Hazzard. (C) wife
(Address) 712 S. 19th. St Philadelphia

15 Filed ..... 192 Robert P. Harrison, Registrar

MAR 28 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Chobolexy.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

(Signed) Wm. C. Reinhardt M. D.
(Coroner.)

March 23 1924 (Address) 1027 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pa Philadelphia Pa — DATE OF BURIAL 3 28 1924

20 UNDERTAKER Harry H Watzke — ADDRESS, 1538 Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Moses Scott)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85356

74-00 b 85356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 761 Lemmon ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Scott

(a) RESIDENCE NO. 761 Lemmon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) July 22, 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
3 +	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Max Kohn

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Moses Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ellen Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. W. Scott

(Address) 761 Lemmon

15 Filed MAR 28 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 22nd, 1924, to March 26, 1924,

that I last saw h alive on March 26, 1924,

and that death occurred, on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Le Roy Ellis, M. D.

19 (Address) 761 Lemmon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	3-29 1924
20 UNDERTAKER George T. A. Gibson	ADDRESS 1735 Ramsay Ave

G. B.—WRITE PLAINLY, WITH UNFADING INK—
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85357

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elizabeth Armstrong

(a) Residence No..... Preston & Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~. (Write the word.)

5a-If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE of~~ William Armstrong

6-DATE OF BIRTH (month, day and year) 1843.

7-AGE, 81 yrs. X mos. X ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles McAllister

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rose Trainor

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland

14-

(Informant) Little Sisters of the Poor

(Address) Preston & Caroline

15-

Filed ..... Robert P. Harrison, Registrar.

MAR 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 27/24

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h. Sr. alive on March 23, 19 24

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. A. Wana, M. D.

3/28/24, 19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, Mar 29, 1924

20-UNDERTAKER, H. C. Weidefeld — ADDRESS 914 Fremont Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 85358

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 85358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2418 Foster Av St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Kerner

(a) Residence No. 2418 Foster Av St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Kerner

6-DATE OF BIRTH (month, day and year) Dec 22-1859

7-AGE. 64 yrs. 3 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Botzler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Babst

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) John Kerner

(Address) 2418 Foster Ave

15- Filed MAR 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 26-24

17- I HEREBY CERTIFY, That I attended deceased from March 16, 1924 to March 26, 1924 that I last saw her alive on March 26 1924 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cancer Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pituitary Insufficiency

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mg

(Signed) D. Lorz M. D.

3/27, 1924 (Address) 3701 Eastern

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Oak Lawn Cemetery	Mar. 29., 1924
20-UNDERTAKER.	ADDRESS
H. Vanderva Sons	210 Hull St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85359

CERTIFICATE OF DEATH.

H60-001

D 85359

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE, (No. St. Agnes Hosp. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clara Phelps

(a) Residence No. Savage, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of W. K. Phelps

6-DATE OF BIRTH (month, day and year) ? 1876

7-AGE 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) W. K. Phelps

(Address) Savage Md

15- Filed Robert P. Harrison, Registrar.

MAR 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/28-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 20 1924 to 3/28 1924

that I last saw h.. alive on 3/28 1924

and that death occurred, on the date stated above, at 12 00 P m.

The CAUSE OF DEATH* was as follows:

? Cerebral Embolus

? Myocardial insufficiency

5 minutes (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exophthalmic Goitre

(Duration) 3-1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of 3/28/24

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. D. Harper M. D

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Savage Md

DATE OF BURIAL. 4/1/24 19 24

20-UNDERTAKER Geo. E. French

ADDRESS Laurel Md

EXACTLY. PHYSICIANS should state CAUSE OF DEATH Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–12-23-21–E.B.R.S.–400 Bks.

D 85360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003

D 85360

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 418 N. Exeter St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Munzia Sutero

(a) Residence No. 418 N. Exeter St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX ~~Male~~ Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3-25-24

7-AGE. yrs. mos. 1 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS:

10-NAME OF FATHER, S. Sutero

11-BIRTHPLACE OF FATHER (city or town) Italy (State or Country),

12-MAIDEN NAME OF MOTHER, Carmela Di Forte

13-BIRTHPLACE OF MOTHER (city or town) Italy (State or Country),

11- (Informant) Salvatore Sutero.

(Address) 418 N. Exeter St.

15- Filed MAR 28 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-26-24

17- I HEREBY CERTIFY, That I attended deceased from 3-25- 1924 to 3-26 1924

that I last saw him alive on 3-26 1924

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Craniorachischisis (monstrosity of birth)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. D'Emanuele, M. D

3-28 1924 (Address) 1804 Lindenau

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Vincent Cemetery | DATE OF BURIAL. 3/28/1924

20-UNDERTAKER, George J. Rutt | ADDRESS 1325 Hanford Ave

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85361

CERTIFICATE OF DEATH.

90

D 85361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Light St. ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Clayland.

(a) RESIDENCE No 1411 Patapsco St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of XXXXXXXX (or) Wife of XXXXXXXX Lula Clayland.

6 DATE OF BIRTH (month, day, and year) April 5, 1874.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Proprietor of
(b) General nature of industry, business, or establishment in which employed (or employer) Pool Room.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Daniel L. Clayland.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emily Hendricks.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Lula Clayland (wife)
(Address) 1411 Patapsco St

15 Filed MAR 28 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Bernhardt M. D.
(Coroner.)

March 28, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Mar 29 192

20 UNDERTAKER Joseph B. Cook ADDRESS 603 N Gilmor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85362

CERTIFICATE OF DEATH. 129

D 85362

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4012 Bonner Road ST., 15 WARD)

2-FULL NAME Georgetta Elizabeth Bobart

(a) RESIDENCE NO. 4012 Bonner Road, ST., Forest Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C. Bobart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	69 approx			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va

PARENTS

10 NAME OF FATHER Geo. A. Schley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Elizabeth Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Paul E. Bobart

(Address) 4012 Bonner Road

15 Filed MAR 29 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1924, to March 28, 1924.

that I last saw her alive on March 28, 1924,

and that death occurred, on the date stated above, at 12:20 a m.

The CAUSE OF DEATH* was as follows:

Phlebitis (Septicemia)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Nephritis (Chronic Interstitial)

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings and Clinical Symptoms

(Signed) Jos. H. Hunter, M. D.

March 29 1924 (Address) 1120 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	3-29 1924
20 UNDERTAKER W. J. Tickner & Sons	ADDRESS North & Penna. Ave.

Burial Permit Clerk

R.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED EXACTLY. PHYSICIAN'S
E should be stated EXACTLY. PHYSICIAN'S should state
mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec–12-23-2!–E.B.R.S.–400 Bks.

D 85363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 85363

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2642 Maryland Ave. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Katherine Kerp

(a) Residence No. 2642 Maryland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Theodore F. Kerp

6-DATE OF BIRTH (month, day and year): Apr. 17 1840

7-AGE: 83 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: John P. Haskell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.

12-MAIDEN NAME OF MOTHER: ? Akers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md.

11-(Informant): Mrs. Cora Woodall

(Address): 2642 Marylandave

15-Filed Mar 28 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 28, 1924

17-I HEREBY CERTIFY, That I attended deceased from Mch 27 1923 to Mch 28 1924

that I last saw h. alive on Mch 27 1924

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis

(Duration) ..... yrs. 1 mos. day ds.

CONTRIBUTORY (Secondary) Cerebro Sclerosis

(Duration) ..... yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

Mch 28 1924 (Address) 1120 W. 20th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Mar. 31 1924

20-UNDERTAKER: Wm J. Pickerson Sons

ADDRESS: North Ave

MAR 29 1924

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1913 Riggs Ave St., 16 Ward) 160

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Shagoque

(a) Residence No. 1913 Riggs Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar. 28 1924

7-AGE. 0 yrs. 0 mos. 0 ds. If LESS than 1 day, ... hrs. or. 2 min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md

PARENTS.

10-NAME OF FATHER, Milton J. Shagoque

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country)

12-MAIDEN NAME OF MOTHER, Mary Catherine Elder

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country)

14- (Informant) Mrs. M. J. Shagoque
(Address) 1913 Riggs Ave

15- Filed MAR 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 28 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 26th 1924 to Mar 28 1924 that I last saw h.. alive on Mar 28th 1924 and that death occurred, on the date stated above, at 9:42A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ..... yrs. ..... mos. one ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. E. Poulton, M. D.

3/29, 1924 (Address) 3909 Gunison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cem.	Mar 29 1924
20-UNDERTAKER	ADDRESS
Wm. Pickney & Sons	Penna & North

WHITE PAPER. INK should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85365

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3913 Walbrook Ave. ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Pryor

(a) RESIDENCE. No. 3013 Walbrook Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M.

6 DATE OF BIRTH (month, day, and year) Nov 6. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Sanner

(Address) 2936 Edmonson Ave.

Filed MAR 29 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 27, 1924, that I last saw him alive on March 27, 1924, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Austin F. Robinson, M. D.

3/28 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Mar 29 1924

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 85366

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85366

CERTIFICATE OF DEATH. X 155

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Hinton

(a) RESIDENCE NO. 100 S. Saint Asaph St. Alexandria, Va ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 23 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 4, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~F~~	23	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... No

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) ..... Va.

PARENTS

10 NAME OF FATHER Harry M. Hinton

11 BIRTHPLACE OF FATHER (city or town) (State or country) ..... Va

12 MAIDEN NAME OF MOTHER Penilly Doggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ..... Va

14 Informant (Address) Patient — L. Hinton.

15 Filed ..... Robert P. Harrison, Registrar

MAR 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1924, to March 28, 1924, that I last saw her alive on March 28, 1924, and that death occurred, on the date stated above, at 6 55 P m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis — Chronic

Nat. T. B (duration) 14 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Surgical Operation —

Arthroplasty Hip (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? Yes Date of March 28, 1924

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Donald C Chandler, M. D.

, 19 (Address) Union Memorial Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexander Va — DATE OF BURIAL Mar 29 1924

20 UNDERTAKER Geo W Little — ADDRESS 2700 Elmwood Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

D 85367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85367

CERTIFICATE OF DEATH.

90

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 105 N Baltimore ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Archie M. Cossitt

(Residence in Baltimore: No. 3349 Windsor Ave ST. 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Married

6-DATE OF BIRTH, September 6, 1868
(Month) (Day) (Year)

7-AGE, 55 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Advertising Agt. Mgr.
(b) General nature of industry, business, or establishment in which employed (or employer): Baltimore Sun

9-BIRTHPLACE, (State or Country), Canada

PARENTS.

10-NAME OF FATHER, L. Cossitt

11-BIRTHPLACE OF FATHER (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Mary McCallum

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Lake Jones

(Address) Utica N. Y.

15-

Filed ..... 19.. Robert P. Harrison Registrar.

MR 29 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 26th, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(2) Cerebral Hemorrhage

(1) Valvular heart

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)

March 29, 1924 (Address) 1058 Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Albany New York

DATE OF BURIAL, March 29, 1924

20-UNDERTAKER Henry H. Jenkins Sons Co.

ADDRESS Cathedral & Centre Sts.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Franklin C. Cooper

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85368

D 85368

CERTIFICATE OF DEATH.

188-103

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ~~Frank. Cooper~~

(a) RESIDENCE NO. 322 Fort Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Cooper

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	4/1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steel. Erect
(b) General nature of industry, business, or establishment in which employed (or employer) worker
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) France

PARENTS

10 NAME OF FATHER ? Cooper

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

MAR 29 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 4 p.m. 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: about

Fract. dislocation ankle — 9 days
caused by auto pulling cable wound foot
accidentally as [illegible] driver of automo
concerned (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gas. bacillus
Suicide? (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Ruhrah, M. D.
(Coroner)
March 29 192 - (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 4 days
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 3/29 1924

20 UNDERTAKER J. Lake Dixon ADDRESS 1318 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85369

D 85369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 842 W Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Thompson

(a) Residence No. 842 W Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Laura B Thompson

6-DATE OF BIRTH (month, day and year) Oct 27-1847

7-AGE, 77 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Sweden

PARENTS.

10-NAME OF FATHER, Axel Bowen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Sweden

12-MAIDEN NAME OF MOTHER, Axel Bowen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Sweden

14- (Informant) Allen D Thompson

(Address) 1449 Covington St

15- Robert P. Harrison, Registrar.

MAR 29 1924 Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 27/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 25/24, 19..., to March 27/24, 19..., that I last saw him alive on March 27/24, 19..., and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:

(Valvular Heart Disease
Mitral Insufficiency

Primal (Duration) yrs. 1½ mos. ds.

CONTRIBUTORY Diabetes
(Secondary)

(Duration) yrs. 1½ mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H D Hall, M. D.

March 28/24 (Address) 1203 High

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cem

DATE OF BURIAL. March 31, 1924

20-UNDERTAKER. Geo Corbin Sons

ADDRESS 2334 Gilmor St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 85370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85370

CERTIFICATE OF DEATH. X 188-003

1-PLACE OF DEATH

CITY OF BALTIMORE, No. Bay View Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Dembofske

(a) RESIDENCE NO. 633 W. Franklin ST., WARD New York N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Dembofsky

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. Y.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Dembofsky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Lend

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Nathan Dembofsky
(Address) N. Y.

15 ....., 192.... Robert F. ..... Registrar

MAR 29 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto Accident
(Duration) 1 hr. mos. ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. 4 ds.

(Signed) G E Blade, M. D.
(Coroner.)
3/29/24 (Address) 143 W Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City-N Y — DATE OF BURIAL Mch 29 1924

20 UNDERTAKER John O Mitchell — ADDRESS 1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Cor.—1-12-26—M&T—100 Blks.

D 85371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85371

CERTIFICATE OF DEATH. X 188-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ludovico Tedoldi

(a) RESIDENCE NO. 633 N. Franklin ST., WARD New York N. Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10 NAME OF FATHER Lodovico Tedoldi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Jack Rosenfeld
(Address) 624 W Franklin St

15 MAR 29 1924 192.. Robert P. Harrison Registrar

Burial Permit filed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto accd.

(duration) hrs. yrs. mos. hrs.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) G E Osler, M. D.
(Coroner.)

3/29/24 192.. (Address) 143 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York N.Y.	Mch 29 192 4
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' and undertakers' reports may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(James Simms)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85372

CERTIFICATE OF DEATH.

122

D 85372

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 8th St Fairfield ST. 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Simms

(Residence in Baltimore: No. 8th St Fairfield St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... Sept (Month) 26 (Day) 1923 (Year)

7-AGE, ... 1 yrs. ..... 6 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(h) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Wm. Harris

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Maggie Simms

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Simms

(Address) 8th St Fairfield Md

15-

Filed ..... 191.....

Robert P. Harris

Registrar.

MAR 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3/28 (Month) (Day), 1924 (Year)

17-I HEREBY CERTIFY, That I attended deceased from 3/25 1924, to 3/28/24 1924, that I saw h[illegible] alive on 3/28/24 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) H A Brunst M. D.

3/28, 1924 (Address) 1340 Division

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Furnace Branch	March 30, 191...
20-UNDERTAKER	**ADDRESS**
H. R. Brown & Son	16 E. Monty st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85373

CERTIFICATE OF DEATH. 100-001

D 85373

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Laurens ST., 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Coles

(a) RESIDENCE NO. 1502 Laurens ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Eddie Coles

11 BIRTHPLACE OF FATHER (city or town) Chesterfield Co
(State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Wright

13 BIRTHPLACE OF MOTHER (city or town) Northumberland Co
(State or country) Va

14 Informant Eddie Coles
(Address) 1502 Laurens St

15 Robert P. Harrison, Registrar

MAR 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28. 1924

17

I HEREBY CERTIFY, That I attended deceased from March 27th, 1924 to March 28th 1924

that I last saw her alive on March 27th, 1924

and that death occurred, on the date stated above, at 1:45 a. m.

The CAUSE OF DEATH* was as follows:

Lob. Bronchopneumonia.

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Streptococcus Infection

(duration) ..... yrs. 7 mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Craig M. D.

3/28. 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Mt Auburn	
20 UNDERTAKER [redacted]son	ADDRESS 1450 North

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state name should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Pollack

D 85374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85374

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1005 Spruce ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Palucki

(a) RESIDENCE NO. 1005 Spruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Wozikowsky

6 DATE OF BIRTH (month, day, and year) 2/1/1866

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	58	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Anthony Palucki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant (Address) Joseph Palucki 1005 Spruce St

15 Filed MAR 29 1924 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1924

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to March 27, 1924, that I last saw him alive on March 27, 1924, and that death occurred, on the date stated above, at 3 00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Neal A. Dougherty, M. D.

3/27, 1924 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 3/31/1924

20 UNDERTAKER Charles B. Kuchawska

ADDRESS 637 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85375

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1914 N. Mulberry St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ralph Henry Loocke

(a) Residence No. 1914 N. Mulberry St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 20-1920

7-AGE. 4 yrs. 1 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER Henry St. Loocke

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Baltimore, Md

12-MAIDEN NAME OF MOTHER Mae Seibel

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Baltimore, Md

14- (Informant) Henry St. Loocke

(Address) 1914 N. Mulberry

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

MAR 29 1924

Burial permit clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/27/24

I HEREBY CERTIFY, That I attended deceased from 3/18, 19 24 to 3/27, 19 24

that I last saw him alive on 3/27, 19 24

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Meningitis (streptococcus)

(Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) J. Heller Hemming, M. D.

3/29, 19 24 (Address) 2000 Hollins St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. Mar 29, 19 24

20-UNDERTAKER. J. B. Heppert — ADDRESS 2336 Fred'k Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85376

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85376

153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Ralph S Phillips

(a) RESIDENCE NO. 508 W. Fremont ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a ~~If married~~, widowed, ~~or divorced~~ HUSBAND of ~~or WIFE of~~ Mary A. Wedden

6 DATE OF BIRTH (month, day, and year) Dec. 26-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
54				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Picture frame Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Wm A. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Wedden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Patient Florence Yost

(Address) 508 W Fremont Ave

15 Filed 3 9 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28- 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to 3-28-24 19..., that I last saw him alive on 3-28, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia (Staph. Aureus)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cellulitis of left hand and arm (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes (Date of) 3-18-24 3-26-24

Was there an autopsy? No 3-28-24

What test confirmed diagnosis? Clinical + Lab.

(Signed) Jno A Dempsey M. D.

, 19 (Address) 1400 Eutaw pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Mar 31 1924

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85377

CERTIFICATE OF DEATH.

166 D 85377

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Valley ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Keenan

(a) RESIDENCE NO. 925 Valley ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. J. Keenan

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER M. Galleger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) B

14 Informant Mr. Edward Keenan

(Address) Owt Valley St

15 Filed ..... 192 ..... Registrar

MAR 29 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

"Burns over almist entire body (Poured coil oil over self & clothing and set fire to same. SUICIDE)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Insanity (duration) 2 or 3 yrs. ..... mos. ..... ds.

(Signed) J. S. N. Culler, M. D.

(Coroner.)

Mar 29/24. 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL March 31 1924

20 UNDERTAKER Henry Stoeckert Sons — ADDRESS 130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85378

CERTIFICATE OF DEATH.

57

D 85378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 677 W. Fayette ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miriam Gold

(a) RESIDENCE NO. 677 W. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Max Gold.

6 DATE OF BIRTH (month, day, and year) July 15-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56 yr	8 mo	13 da.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER — Hundleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Esther —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant David Gold.
(Address) 602 W. Baltimore St.

15 Filed MAR 29 1924, 19..... Robert F. Carrigan, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924.

17 I HEREBY CERTIFY, That I attended deceased from January 1 1918 to March 28 1924.; that I last saw her alive on March 27 1924, and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart.

(duration) sudden.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urinalysis & physical Signs

(Signed) Chester Ruland, M. D.

3-28, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL Mar. 30 1924

20 UNDERTAKER Levinson & Sons

ADDRESS 1127 E Bolton St

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85379

D 85379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Margaret Wilson

(a) RESIDENCE NO. #2 Eutaw Ave, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of William Wilson

6 DATE OF BIRTH (month, day, and year) Dec. 26th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J Bell

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant William Wilson
(Address) 2 Eutaw Ave.

15 Filed MAR 29 1924, 19 Robert P. Harrison, Registrar

Burial permit issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 23rd, 1924, to March 27th, 1924,

that I last saw h~~er~~ alive on March 27th, 1924,

and that death occurred, on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus, Hypertension, Chronic Nephritis.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. findings.

(Signed) James D. White, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer M. E. Cemetery	Mar. 30 1924
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85380

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85380

CERTIFICATE OF DEATH. 65-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 607 St. Paul St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mark Owings Shriver

(a) Residence No. 607 St. Paul St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katharine Dietrich

6-DATE OF BIRTH (month, day and year) Mar. 3, 1842

7-AGE.	If LESS than 1 day,
82 yrs. 0 mos. 25 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired - Canner

(b) General nature of Industry, business, or establishment in which employed (or employer): and Packer

(c) Name of employer:

9-BIRTHPLACE (city or town) Union Mills
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Shriver

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary M. J. Owings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

11- (Informant) Mark O. Shriver Jr.
(Address) 607 St. Paul Street

15- Filed ... 192... Robert P. Harrison, Registrar.

MAR 29 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 28. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 20 19 24, to March 28 19 24

that I last saw h.. alive on ...ch 28 19 24,

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Splenic Leukaemia

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) ... yrs. ... mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles O Brosius M. D

March 29, 1924 (Address) 5 E. Read St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	3/31 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85381 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 85381

CERTIFICATE OF DEATH. 7 452

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1023 Dallas St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand L. Van Rossum

(a) Residence No. 1023 Dallas St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Schonberger

6-DATE OF BIRTH (month, day and year) May 12, 1887

7-AGE.	If LESS than 1 day.
36 yrs. 10 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Sheet Metal Worker

(b) General nature of Industry, business, or establishment in which employed (or employer): E. W. Schultz & Sons

(c) Name of employer: Baltimore

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER, William Van Rossum

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER, Catherine Plummer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant) Mrs. Kate Van Rossum

(Address) 1023 Dallas St.

15- Filed MAR 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 26

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923 to March 26, 1924

that I last saw h-- alive on ....., 19.....,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Intestines

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Contributory

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. L. Long M. D

3/29, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Carmel Cemetery	3/29, 19.24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 85382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Dolphin ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Morsell.

(a) RESIDENCE NO. 730 Dolphin st ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 3' yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19, 1903.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	—	3	7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer Holeman & Co- Calvert Co Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Garry H. Morsell

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Reed

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md

14 Informant Lillian Kelley

(Address) 730 Dolphin st

15 MAR 29 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27th 1924

17. I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1924, to Mar 27th, 1924, that I last saw her alive on Mar 26th, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis (Non-Puerperal) following Acute Appendicitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Harry F Brown M. D.

3/27/1924 (Address) 1501 Prastman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremated Baltimore Md	Mar 30 1924
20 UNDERTAKER	ADDRESS
Mc. R. C. Elliott	Parkland Inc

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85383

CERTIFICATE OF DEATH.

129

D 85383

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4205 Walnut ave. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Weyler

(a) RESIDENCE NO. 4205 Walnut ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Hillen Weyler

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co, Md

PARENTS

10 NAME OF FATHER August Weyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lentz, now-

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe.

14 Informant Mrs. William Thomas (Address) 2 Lidenwood St

15 Filed MAR 29 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1924

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to Mch 28, 1924, that I last saw him alive on March 28th, 1924, and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscop. & Chem.

(Signed) August Thorn, M. D.

, 19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	March 31 1924
20 UNDERTAKER Margaret L. Flynn	ADDRESS 1422 Light St.

8.—WRITE PLAINLY, WITH UNFADING INK. THIS ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... certificates.

Spec.—1-10-21—M&T—1500 Bks.

(John F. Creager)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85384

CERTIFICATE OF DEATH. X

38 D 85384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Creager

(a) RESIDENCE NO. Granite Md St., WARD Granite Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Creager

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Empire Stone Co

(c) Name of employer Granite Quarry and

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER David Creager

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Matilda Roberts

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Asphalt Roads

(Address)

15 Filed MAR 29 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29/24

17

I HEREBY CERTIFY, That I attended deceased from 3/24/24, 19..., to 3/29/24, 19...

that I last saw h— alive on 3/29/24

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Aortic & Mitral Incompetency

Cardiac Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Labs

(Signed) H. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Granite Md.

DATE OF BURIAL Mar 1924

20 UNDERTAKER J. R. Steed

ADDRESS Sykesville

Burial Permit Issued

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EV... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85385

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85385

CERTIFICATE OF DEATH.

4 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Robinson

(a) Residence No. 130 Grace Court St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Sgl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 50-60 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Work D.C

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAR 29 1924, 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-27-24

17- I HEREBY CERTIFY, That I attended deceased from 3-26....., 1924 to 3-27., 19.24

that I last saw him alive on 3-27., 19.24

and that death occurred, on the date stated above, at 2^10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic myocarditis

Myocardial degeneration

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude S. Dixon, M. D.

3-28-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Auburn Cem.	March 31, 1924.
20-UNDERTAKER. Samuel T. Hensley	ADDRESS 978 N. Bond St.

JK.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85386

CERTIFICATE OF DEATH.

57 V

D 35386

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie White

(a) Residence No. 1207 Myrtle Ave. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) St. Marys County (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Grandson Barnes

11-BIRTHPLACE OF FATHER (city or town) St. Marys Co. (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Lizzie B. Jones

13-BIRTHPLACE OF MOTHER (city or town) St. Marys Co. (State or Country), Maryland

14- (Informant) Henry White

(Address) 1207 Myrtle Ave

15- Robert F. [illegible]

Dic... 192... Registrar.

MAR 29 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/27/24

17- I HEREBY CERTIFY, That I attended deceased from March 26 1924 to March 27 1924

that I last saw her alive on March 27 1924,

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Gas Gangrene

4 Hours

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of March 24 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M. J. Fulton M. D.

19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	March 30 1924
20-UNDERTAKER.	ADDRESS
Samuel T Hensley	578 W Biddle

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

D 85387

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85387

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Lloyd ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Diamunzio

(a) RESIDENCE. NO. 204 Lloyd ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Nick Diamunzio

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Rhoades

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Nick Diamunzio
(Address) 204 Lloyd

Filed MAR 29 1924 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 24 1924 to March 29 1924 that I last saw h alive on March 29 1924 and that death occurred, on the date stated above, at 6A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

3/29 1924 (Signed) Israel Feinglos M. D.

(Address) 2002 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 31 1924
20 UNDERTAKER Minnie Duffy & Son	ADDRESS 326 N.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85388

D 85388

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 20 W. Madison St., 11 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Kitchell

(a) Residence No. 20 W. Madison St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank P. Kitchell

6-DATE OF BIRTH (month, day and year) Aug 9 1867

7-AGE. 56 yrs. 7 mos. 14 ds. If LESS than 1 day ....hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... house duties

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER Jacob Burkhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Switzerland

12-MAIDEN NAME OF MOTHER Phoebe Jacobs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna.

14-

(Informant) Grace B. Adams

(Address) 2917 St Paul St

15-

Filed MAR 29 1924 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 28-24

17- I HEREBY CERTIFY, That I attended deceased from Dec 23, 1923 to March 28, 1924.

that I last saw h.e alive on March 26, 1924

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Duration) yrs. mos. 15 Days ds.

CONTRIBUTORY (Secondary) arterial hypertension

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure test

Mch 29 1924 (Signed) H Warren Buckler M. D.
(Address) 606 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL.

Mount Olivet Cem. March 31, 1924

20-UNDERTAKER — ADDRESS

John O. Mitchell 1201 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

89 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85389

181-001

D 85389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1326 N. Dallas ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca M. Seibold

(a) RESIDENCE No 1326 N. Dallas ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Seibold

6 DATE OF BIRTH (month, day, and year) Feb 26/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Michael Strauss

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Esther Strauss

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant William Seibold
(Address) 1326 N. Dallas

15 Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Illuminating
Hypostatic Pulmonary
Congestion - (Disconnected
Tube from heating Stove
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wallis, M. D.
(Coroner.)

Mar 28, 1924 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	March 30 1924
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	16 N. Mad

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85390

CERTIFICATE OF DEATH.

40 ✓

86-40 D 85390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 Aster Place St.) (15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred L Loughlin

(a) RESIDENCE NO. 2532 Aster Place St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 13/19

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jersey City N J

PARENTS

10 NAME OF FATHER Fred L Loughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland Ruby

12 MAIDEN NAME OF MOTHER Jersey City N J.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Fred Loughlin (Address) 2532 Aster Place

15 Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924, to March 28, 1924, that I last saw h[illegible] alive on March 28, 1924, and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute pharyngitis.

Otitis Media (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Smear of Pus Streptococci in

(Signed) Harry D. McCarty M. D.

3-28, 1924 (Address) 37 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jersey City N J. DATE OF BURIAL: March 30 19

20 UNDERTAKER: M. Healy & Sons. ADDRESS: 1827 N Front

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

✓ 85391

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 85391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 S Luzerne Ave ST.; 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Hahuelska

(a) RESIDENCE. NO. 832 S Luzerne Ave ST., 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs — mos. — ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 21-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walenty Kordowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Kate Pakulska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant John Hahuelski
(Address) 832 S Luzerne Ave

15 Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 25 1924 to March 27 1924 that I last saw her alive on March 27 1924 and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Berkowitz M. D.

3-28-24 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	Mar 31 1924
20 UNDERTAKER	ADDRESS
Stefan Stalkowski	101 S Kenwood Ave

A. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85392

CERTIFICATE OF DEATH.

100-00 85392

D 85392 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Hollins ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vivian E. King,

(a) RESIDENCE No. 821 Hollins. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) July 31, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael J. V. King, Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary E. Bender.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Michael J. V. King. Jr.

(Address) 821 Hollins St

15 MAR 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28. 1924.

17

I HEREBY CERTIFY, That I attended deceased from Mar. 26. 1924. to Mar. 28. 1924.

that I last saw h[illegible] alive on March. 28. 1924.

and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho - Pneumonia. (Primary).

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical findings

(Signed) Thos. Corkey, M. D.

(Address) 888 N. Loudon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 31. 1924
20 UNDERTAKER	ADDRESS
John Grebliauskas	425 S. Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85393 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 85393

CERTIFICATE OF DEATH. 46 D 85393

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 692 Pine St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Rogers

(a) Residence No. 692 Pine St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) 1862

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Leesburg Co Va

PARENTS.
10-NAME OF FATHER, Lewis Curtis
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.
12-MAIDEN NAME OF MOTHER, — — —
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14- (Informant) Edward Rogers (Address) 692 Pine St

15- MAR 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 2, 1924, to March 27, 1924, that I last saw her alive on March 26, 1924, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. L. Coakley M. D.

19 (Address) 153 Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Leesburg Co Va. DATE OF BURIAL, April 1, 1924

20-UNDERTAKER, Samuel T Hensley ADDRESS 570 N Bridge

JA

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85394

CERTIFICATE OF DEATH.

85394

90 D 85394

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1263 James St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Farmer

(a) Residence No. 1263 James St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo F Farmer

6-DATE OF BIRTH (month, day and year) Aug 24

7-AGE, 70 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer)..... Ink

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), England.

PARENTS.

10-NAME OF FATHER, Minnett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Eng

12-MAIDEN NAME OF MOTHER, Mt Kinn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Mt Kinn

14- (Informant) Jane Farmer

(Address) 1263 James St

15- MAR 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 29/24

17- I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to March 29, 1924, that I last saw her alive on March 29, 1924, and that death occurred, on the date stated above, at 8 am.

The CAUSE OF DEATH* was as follows:

I Acute Cardiac Dilitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar E. Tavares M. D.

, 19 (Address) 1500 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Greene Lawn	April 1, 1924
20-UNDERTAKER,	ADDRESS
W M Routson	2238 N Smith

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85395

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 Sarah Ann St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry M. Schneider

(Residence in Baltimore: No. 611 Sarah ann st- St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. Jan (Month) 7 (Day) 1876 (Year)

7-AGE.	If LESS than 1 day.
48 yrs. 2 mos. 19 ds.	....hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cemetery 083
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Edw Schneider

11-BIRTHPLACE OF FATHER, (State or Country), N. Y

12-MAIDEN NAME OF MOTHER, Krauter

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Catherin Schneider

(Address) 838 S Paca st

15- MAR 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 26 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said.....Inquest, autopsy or Inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs. mos. ds.

(Signed) H R Jamison M. D. (Coroner.)

3-29 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	March 31, 1924
20-UNDERTAKER,	ADDRESS
W M Routson	2235 N Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 85396

D 85396
Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 2528 E. Fayette St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Morris Levenson

(a) Residence No. 2528 E. Fayette St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
63 yrs. — mos. — ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Benjamin Levinson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Harry Levin
(Address) 23 N. Collington Ave.

15- MAR 30 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 29/24

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to March 29, 1924, that I last saw h[illegible] alive on March 29, 1924, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Leidel M. D.
, 19 (Address) 2404 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.).

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Henry Rm	3/30 1924
20-UNDERTAKER	ADDRESS
Sol Levinson & Bro	1124 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Horace Madary.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85397. ✓

D 85397.

CERTIFICATE OF DEATH.

X 65-001

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Madary

(a) RESIDENCE NO. Jamestown Co. Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) School boy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Hospital Records (Address)

15 Date MAR 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/1924.

17 I HEREBY CERTIFY, That I attended deceased from Oct 3-23, 19..., to 3/30/24, 19..., that I last saw h— alive on 3/30/24, 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Uremia - Nephritis
Lumbago

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab.

(Signed) K. V. Dooley, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown Md

DATE OF BURIAL April 2 24

20 UNDERTAKER W M Routson

ADDRESS 2238 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

Dr Zeiler, 1123 Poplar Grove ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85398

CERTIFICATE OF DEATH.

1924 D 85398

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 832 Calverton Road St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora E Talbott

(a) Residence No. 832 Calverton Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Joshua S

6-DATE OF BIRTH (month, day and year): May 8, 1865

7-AGE: 58 yrs. 10 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS

10-NAME OF FATHER: Thomas A Prance

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md.

12-MAIDEN NAME OF MOTHER: Sarah Jane Steve

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

11-Informant: Joshua S Talbott

(Address) 832 Calverton Road

13-MAR 30 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1923 to March 29 1924

that I last saw her alive on March 29 1924

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Uremia poisoning due to

Nephritis—

(Hemiplegia six months ago)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 10 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jno N Zeiler, M D

3/30/1924 (Address) 1123 Poplar Grove

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn DATE OF BURIAL. Mar 31 1924

20-UNDERTAKER: Wm Cook ADDRESS 502 E Gath Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 132

D 85399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Duron.

(a) RESIDENCE NO. 132 Welch St. ST., WARD Mt. Airy N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19, 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Paul Duron.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mattie Hodge.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mrs Paul Duron

(Address) Mt Airy N C

15 Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1924 to March 29, 1924, that I last saw him alive on March 29, 1924; and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec. 11, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Blood Chemistry + Urine exam.

(Signed) H. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Airy N.C

DATE OF BURIAL 3/31 1924

20 UNDERTAKER Wm Cook

ADDRESS 502 E Main

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85400

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 21 S. Linwood ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Edward M. Clarke

(a) Residence No.... 21 S. Linwood ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Clarke

6-DATE OF BIRTH (month, day and year) Sept. 25-1870

7-AGE, 53 yrs. 5 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... asst. Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Ind. Laundry Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER Martin Clarke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Jane O'Farrell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Annie Clarke

(Address) 21 S. Linwood ave

15- Filed MAR 30 1924 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/28/24.

17- I HEREBY CERTIFY, That I attended deceased from Jan, 1924, to Mch 28, 1924, that I last saw h.. alive on Mch 28, 1924, and that death occurred, on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Chas F Blake, M. D.

Mch 24 1924 (Address) 20 N Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral	3/31, 1924
20-UNDERTAKER, J. G. Moran	ADDRESS 3000 E. Baltimore

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85401 ✓

D 85401

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Shirey Ave. Hamilton ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. German

(a) RESIDENCE No. 10 Shirey Ave. Hamilton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura V. Eder

6 DATE OF BIRTH (month, day, and year) Sept 20th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	67	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) R. R.

(c) Name of employer

0713

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua German

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Fowler

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant W. E. Pitts
(Address) 10 Shirey ave. Hamilton

15 Filed MAR 30 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 5 , 1924 , to Mar. 28 , 1924 ,

that I last saw h— alive on Mar. 28 , 1924 ,

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Hayes, M. D.

3-30 1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	March 31 1924
20 UNDERTAKER	ADDRESS
Fredk Lassahn Sons	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PENCIL should not be used. Every question should be answered. If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 85402 — 1-PLACE OF DEATH

90 D 85402 — REGISTERED NO.

CITY OF BALTIMORE: (No. 3617 Fairview Ave. St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David M.Ambach

(Residence in Baltimore: No. 3617 Fairview Ave. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED
Male	White	Married.

6-DATE OF BIRTH: Jany. 19, 1870. (Month) (Day), 1 (Year)

7-AGE: 54 yrs. 2 mos. 9 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Clothing
(b) General nature of Industry, business, or establishment in which employed (or employer): Manufacturer.

045

9-BIRTHPLACE (State or country): Baltimore, Md.

PARENTS

10-NAME OF FATHER: Michael Ambach

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Jennie Burgunder.

13-BIRTHPLACE OF MOTHER (State or country): Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mrs.Hilda Ambach

(Address): 3617 Fairview Ave.

15- Filed MAR 30 1924 191 ROBERT R. KRAUPER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Mar. (Month) 28 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4-1, 1924, to, 4-28 1924, that I saw him alive on 4-28 1924, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema a
Cardiac decompensation

(Duration) yrs mos. 1 ds.

Contributory (SECONDARY) Hypertension. Cardio Vascular Disease.

(Duration) yrs mos. ds.

(Signed) Cohen & Felsenfeld M. D.

4-28, 1924. [Address] 7806 Garrison

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Hebrew Cem.

DATE OF BURIAL: 3/30/24. 191

20-UNDERTAKER: David Sondheim

ADDRESS: 18-38 W. Mt. Royal Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 85403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 D 85403

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva D. Bray

(a) RESIDENCE NO. Stevenville Md ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 24 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 21 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. P. Bray.

6 DATE OF BIRTH (month, day, and year) April 1 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER J. E. Eggleston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Francis Fulcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant University Hospital Records
(Address)

15 Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to March 29, 1924, that I last saw her alive on March 29, 1924, and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia Phthisis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Findings

(Signed) John M. Edmonds, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Martinsville Va	April 1 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85404

CERTIFICATE OF DEATH.

101-00 D 85404

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 N Arlington Ave ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie May Cresswell

(a) RESIDENCE NO. 1004 N Arlington Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Cresswell

6 DATE OF BIRTH (month, day, and year) April 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER J H Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C.

12 MAIDEN NAME OF MOTHER Cornelia Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Cornelia Marshall (Address) 1004 N Arlington Ave

15 MAR 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1924, to March 29, 1924, that I last saw h[illegible] alive on March 29, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 1704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 31 1924
20 UNDERTAKER	ADDRESS
Harman & Wright	364 W Cam

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85405

CERTIFICATE OF DEATH.

X 131 D 85405

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Williams.

(a) RESIDENCE NO. Cardiff Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Elmer Williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	32	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

876

9 BIRTHPLACE (city or town) (State or country) Cardiff Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Elmer Williams

(Address) Cardiff Md

MAR 30 1924 Filed ..... 19.....

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 24

17

I HEREBY CERTIFY, That I attended deceased from March 28, 19 24, to March 30, 19 24,

that I last saw him alive on March 30, 19 24,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Bilateral Hydronephrosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James Hurst Wilkerson M. D.

, 19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. J. Tichnerton

DATE OF BURIAL 4/2 1924

20 UNDERTAKER Cardiff Md.

ADDRESS North Ave

N. B.—WHITE PEARL, WHITE CARNATION OR WHITE ROSE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of c

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85406

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 Dolphin Street ST.: 17 WARD)

2-FULL NAME Edna Sullivan

(a) RESIDENCE. NO. 500 Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertina Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bertina Douglas Mother
(Address) 500 Dolphin Street

15 Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923 to Mar. 28, 1924.

that I last saw her alive on Mar 25, 1924.

and that death occurred, on the date stated above, at 9:15 A.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Thos. Woolsey, M. D.

3-28 1924 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar 31st 1924
20 UNDERTAKER Jas. M. Johnson	ADDRESS 1309 Druid Hill

NOTE.—WRITE LEGIBLY; ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 85407

REGISTERED NO.

1-PLACE OF DEATH Pronounced dead at St. Joseph Hospital

CITY OF BALTIMORE: (No. 1807 St., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse F. Roberts

(a) RESIDENCE NO. 3607 Mt. Pleasant Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Roberts

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma -------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Anna Roberts
(Address) 3608 Mt. Pleasant Ave

15 MAR 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Probably Valvular)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Paul, M. D.

Mar 29/24 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Mch 31 1924

20 UNDERTAKER Lilly & Feile

ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 85408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85408

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1201 Ridgely, ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Mary Demme

(a) RESIDENCE. NO. 1201 Ridgely St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	W.	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John B. Demme

6 DATE OF BIRTH (month, day, and year) April 9 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Christian Altenth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Kater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John B. Demme

(Address) 1201 Ridgely St

MAR 30 1924 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1924, to Mar 29, 1924, that I last saw h[illegible] alive on Mar 28, 1924, and that death occurred, on the date stated above, at 4 10 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no Auscultation

What test confirmed diagnosis?

(Signed) H. S. Hamner, M. D.

, 19 (Address) 18 E Pro Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 1 1924
20 UNDERTAKER Wolff & Little	ADDRESS 750 Edmondson Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 85409

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5516 Garrison Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Schwartz

(a) Residence No. 5516 Garrison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Schwartz

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Edla Zaretsky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Hamosh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Harry Schwartz

(Address) 2529 Druid Park

15- Filed MAR 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-29-24

17- I HEREBY CERTIFY, That I attended deceased from Jan, 19 24 to March 29, 19 24

that I last saw h[illegible] alive on March 29, 19 24

and that death occurred, on the date stated above, at 11 1/2 P m.

The CAUSE OF DEATH* was as follows:

arteio-sclerosis & fracture of hip (3 mos ago)

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz M. D.

3-30, 1924 (Address) 2040 Linton Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale | DATE OF BURIAL, 3-30, 19 24

20-UNDERTAKER, Jack Lourie | ADDRESS 1429 E Baltimore St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85410 — 90 — D 85410

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Summit ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Laughlin

(Residence in Baltimore: No. 19 Summit East St.; 72 yrs., 11 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, April (Month) 12 (Day), 1851 (Year)

7-AGE, 72 yrs. 11 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Henry Andrews

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Rachel A Shipley

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. Walter

(Address) 19 Summit East

15- MAR 30 1924 ROBERT R. KRAUTER, Registrar. Filed....., 191.... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 27 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 4 1924, to March 27 1924, that I saw her alive on March 27 1924 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (Duration) yrs. mos. ds.

(Signed) John D. Barber M. D.

March 27, 1924 (Address) 483 W. Lanvale St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Western Cem — DATE OF BURIAL, 3/31, 1924

20-UNDERTAKER ROBERT BROOKS & SON — ADDRESS Cor Calhoun Baltimore St

FUNERAL DIRECTORS & EMBALMERS

S. E. CORNER CALHOUN & MOLLINS STREETS.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85411

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2425 Christian St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph C. Cuffley

(a) Residence No. 2425 Christian St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (~~Write~~ the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 22—1923

7-AGE, ...yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).... Baltimore Md.
(State or Country).

PARENTS.

10-NAME OF FATHER Newey L Cuffley

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country). Md

12-MAIDEN NAME OF MOTHER, Clara Rosenberger

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country). Md.

14-

(Informant) Clara Cuffley

(Address) 2425 Christian St

MAR 30 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to March 29, 1924, that I last saw him alive on March 28, 1924, and that death occurred, on the date stated above, at 7 15 m.

The CAUSE OF DEATH* was as follows:

Died Collapse

Pul tuberculosis

.....(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis

.....(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Robert C Fitch, M. D.

3-29, 1924 (Address) 2161 Eutaw Pl

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL, March 31, 1924

20-UNDERTAKER, Robt G Turner Sr — ADDRESS 1442 N Broadway

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 85412

D 85412

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4707 York Road, ST. 27 WARD)

REGISTERED NO. 10[illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Roche.

(a) RESIDENCE. No. 4707 York Road, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne McAndrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Dr. Farrell 4707 York Road

MAR 30 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1924, to March 28, 1924, that I last saw her alive on March 28, 1924, and that death occurred, on the date stated above, at 10[illegible]35 p. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. D. Greenhow M. D.

3/29/1924 (Address) 3949 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/31 1924
20 UNDERTAKER J. F. Lahey & Son	ADDRESS 358 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85413

CERTIFICATE OF DEATH.

27 122-002

D 85413

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4801 Augusta Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet E. McGloin

(a) Residence No. 4801 Augusta Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Mar 10 1889

7-AGE. 35 yrs. 0 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)..... Post Office

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Newfoundland

(State or Country), Nfld

PARENTS.

10-NAME OF FATHER, Edward McGloin

11-BIRTHPLACE OF FATHER (city or town)..... New York

(State or Country), NY

12-MAIDEN NAME OF MOTHER, Delia McGough

13-BIRTHPLACE OF MOTHER (city or town)..... New York

(State or Country), NY

14- (Informant) Ethel Marshall

(Address) 4801 Augusta Ave

15- MAR 31 1924 ROBERT N. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 28 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to March 28 1924

that I last saw her alive on March 28 1924

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Sclerosis L Lives

(Duration) 1 yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) O. L. Long M. D.

3/29, 1924 (Address) 1701 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Glen N.Y. DATE OF BURIAL: Mar 31 1924

20-UNDERTAKER: Leo G. Cook ADDRESS: Smith & Hayford Accts

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85414

CERTIFICATE OF DEATH.

D 85414

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. Eastern Av ST., 17 WARD)

REGISTERED NO. 186-023

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie M. Neary

(a) RESIDENCE No 653 N. Franklin ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unborn mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Geo Neary

6 DATE OF BIRTH (month, day, and year) Feb 3rd 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	35	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ——
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Fa

PARENTS

10 NAME OF FATHER Fred M. Montgomery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fa

12 MAIDEN NAME OF MOTHER Ella Mayor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fa

14 Informant Fred M. Montgomery
(Address) Edgewater Rd

15 Filed ..... 192 ..... Registrar

MAR 31 10 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Multiple Fractures Auto Accident

(Duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo B Slade, M. D.
(Corner) 3/30/24, 192 (Address) 2436 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, the Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 31 1924
20 UNDERTAKER F. B. Hesselbrock	ADDRESS 2256 Frederick Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21– E.B.R.S.—400 Bks.

D 85415 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

1925 5 88 1872

CERTIFICATE OF DEATH.

Registered No. D 85415

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C Hohmann

(a) Residence No. 3783 Fourth St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Catherine Hohmann

6-DATE OF BIRTH (month, day and year) Dec 12 1871

7-AGE. 51 yrs. 3 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clothing Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) Hohmann's D&S

(c) Name of employer Baltzine nyd

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER Alfred Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md

12-MAIDEN NAME OF MOTHER Margaret Ferguson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md

14- Mrs Catherine Hohmann (Informant)

(Address) 3783 Fourth St

15- MAR 31 1925 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 29 25

17- I HEREBY CERTIFY, That I attended deceased from March 27 1925 to March 29 1925

that I last saw him alive on March 29 1925

and that death occurred, on the date stated above, at 7 15 AM

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S. Goldman M. D.

, 19 (Address) St Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Ft Cadwalader DATE OF BURIAL. 4/1/25, 19....

20-UNDERTAKER. J B Kepline ADDRESS 2156 Fleet Av.

EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85416

CERTIFICATE OF DEATH.

31 D 85416

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 245 S. Chapel St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Stapleton

(a) Residence No. 245 S. Chapel St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Patrick J. Stapleton

6-DATE OF BIRTH (month, day and year) Oct. 13th 1889

7-AGE. 34 yrs. 5 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: John Herman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Annie Waldmueller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14- (Informant) Patrick J. Stapleton

(Address) 245 S. Chapel St

15- Filed MAR 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1923 to March 27 1924

that I last saw h. alive on March 26 1924

and that death occurred, on the date stated above, at 10 50 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 15 mos. ds.

18-Where was disease contracted if not at place of death? V

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Leo Heller M. D

(Address) 1937 Gough

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	March 31st 1924
20-UNDERTAKER.	ADDRESS
Lilly & Zeller	4033 E. Monument St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85417

CERTIFICATE OF DEATH.

31 D 85417

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 116 N. Hare St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Reabl

(a) Residence No. 116 N. Hare St., 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 30th 1894

7-AGE. 29 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Paul Reabl.

11-BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or Country).

12-MAIDEN NAME OF MOTHER, Katherine Baumstead

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or Country).

14- (Informant) Katherine Reabl Mother

(Address) 116 N. Hare St

15- Filed MAR 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 28th 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1923 to March 28 1924

that I last saw h.e alive on 26 1924

and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. G. Beacom M. D

3 28 1924 (Address) 3907 Fairview Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: April 1st 1924

20-UNDERTAKER: Lilly-Zeiler — ADDRESS: 4033 W. Wolfe St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85418

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. O. Donnell & 22nd St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Loeblein

(a) Residence No. O. Donnell & 22nd St., 26 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Barbara Loeblein

6-DATE OF BIRTH (month, day and year) Nov. 24 1877

7-AGE.	If LESS than 1 day.
46 yrs. 4 mos. 4 ds.	... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Marble

(b) General nature of Industry, business, or establishment in which employed (or employer): Dealer

(c) Name of employer: ...

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Simon Loeblein

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Maria Kleinhauser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) George A. Loeblein Bro.

(Address) O. Donnell & 22nd St.

MAR 31 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 28th 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 25 1924 to Mar. 28 1924

that I last saw h... alive on Mar. 28 1924

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Diffuse Nephritis

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No Urine Analysis

What test confirmed diagnosis? Physical Signs

(Signed) J. Frederick L. Hanes M. D

March 29 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	March 31st 1924
20-UNDERTAKER.	ADDRESS
Lilly & Zeiler	4038 Wolfe St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85419 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85419

1st Cathedral
N. 1682 E Baltimore St

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 117 N. Durham St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph G. Schmidt

(a) Residence No. 117 N. Durham St., 6 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 15 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie A. Schmidt

6-DATE OF BIRTH (month, day and year) Mch 15th 1889

7-AGE. 35 yrs. 13 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Chauffeur

(b) General nature of Industry, business, or establishment in which employed (or employer): 023

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Schmidt

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Katharine Schlaugenhaft

13-BIRTHPLACE OF MOTHER (city or town) York (State or Country), Pa.

14- (Informant) Jennie A. Schmidt

(Address) 117 N. Durham St.

15- MAR 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 30th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 18, 1923 to Mch 30, 1924 that I last saw h[illegible] alive on 3/29, 1924 and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Adeno Sarcoma of whole System

(Duration) 9½ mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes No Date of 7/22/23

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Pathological Exam

(Signed) D. J. Carroll M.D.

, 19 (Address) 1746 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: April 2nd 1924

20-UNDERTAKER: Lilly & Zeiler

ADDRESS 4038 Wash St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 85420

REGISTERED NO.

1-PLACE OF DEATH Hotel Sherwood

CITY OF BALTIMORE: (No. 717 St. Mommouth ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Carlisle Cleland

(a) RESIDENCE NO. 717 St. Mommouth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Margaret H Cleland

6 DATE OF BIRTH (month, day, and year) June 2nd 1854

7 AGE 69 Years 9 Months 27 Days | If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 14 years

(b) General nature of industry, business, or establishment in which employed (or employer) was a member of Burial Board

(c) Name of employer National Casket Co.

9 BIRTHPLACE (city or town) Pittsburgh (State or country) Penna U.S.A.

PARENTS

10 NAME OF FATHER William Cleland

11 BIRTHPLACE OF FATHER (city or town) Crossgar (State or country) Co Down Ireland

12 MAIDEN NAME OF MOTHER Margaret D. Arnold

13 BIRTHPLACE OF MOTHER (city or town) Pittsburgh (State or country) Co Down Ireland

14 Informant Robt. C. Cleland. (Brother)

(Address) P.O. Box 817 Pittsburgh Pa

MAR 31 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from December, 1915, to March 29th, 1924, that I last saw him alive on March 29th, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Urinary Bladder

Recurrent Growth (duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? SEE OTHER SIDE.

Did an operation precede death? Date of Jan. 1915

Was there an autopsy? No

What test confirmed diagnosis? Pathological Exam of Growth

(Signed) Thomas L. Shearer, M. D.

Mch 29th 1924 (Address) 905 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	4-1-1924
20 UNDERTAKER	ADDRESS
J. Perkins Son & Co	Belair Md

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85421

CERTIFICATE OF DEATH.

124 D 85421

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 2139 Vine ST., 70 WARD)

2-FULL NAME Margaret M. Clemmons

(a) RESIDENCE NO. 2139 Vine ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Thom A Clemmons

6 DATE OF BIRTH (month, day, and year) May 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER Alex. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rebecca Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Arthur Schiable

(Address) 113 S. Caroll St

MAR 31 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924 to March 28, 1924 that I last saw her alive on March 28, 1924 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

(duration) 5+ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Coolahan, M. D.

3/29 24, 19 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 31 1924
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Falls Rd

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec. 1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 85422

CERTIFICATE OF DEATH.

D 85422

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Eastern ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Smith

(a) RESIDENCE NO. 402 Eastern ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mamie Thomas
(Address) 711 Argyle St

Filed MAR 31 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1924, to March 28, 1924, that I last saw h alive on March 27, 1924, and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc

(duration) yrs. — mos 21 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles R Flowers M. D.

March 29, 1924 (Address) 712 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL April 1 1924

20 UNDERTAKER Wm. J. McAlexander — ADDRESS 1401 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85423

CERTIFICATE OF DEATH.

31 D 85423

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Bennett Place ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Genevie Abell

(a) RESIDENCE. No. 1001 Bennett Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Testa Abell

6 DATE OF BIRTH (month, day, and year) 3/19/1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm J. McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary T. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Vincent Testa Abell 1001 Bennett Place

15 Filed MAR 31 1924 16 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/3 . 1924 . to 3/20 . 1924 .

that I last saw her alive on 3/17 . 1924 .

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Gruby M. D.

3/20, 1924 (Address) 1426 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	3-31-24

20 UNDERTAKER Henry C. Bramingstt

ADDRESS North & Schroeder Sts

N. B.—MARRIED WOMEN, whether employed or not, should be reported by their own occupation. INFANTS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85424

CERTIFICATE OF DEATH.

31 D 85424

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 349 S. Monroe St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William O. Ford

(a) Residence No. 349 S. Monroe St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Kuely Ford

6-DATE OF BIRTH (month, day and year) July 12/1884

7-AGE. 39 yrs. 8 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer). 31

(c) Name of employer.....

9-BIRTHPLACE (city or town). a.a.Co. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George G. Ford

11-BIRTHPLACE OF FATHER (city or town). a.a.Co. (State or Country), Md

12-MAIDEN NAME OF MOTHER Susan C. Carr

13-BIRTHPLACE OF MOTHER (city or town). Md. (State or Country),

14- (Informant) Ella N. Ford

(Address) 349 S. Monroe St.

15- FILED MAR 31 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mch 29/24

17- I HEREBY CERTIFY, That I attended deceased from July 2, 1923 to Mch 29, 1924 that I last saw h. alive on March 28 1924 and that death occurred, on the date stated above, at 11.40 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary and laryngeal Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Insanity

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Probably Balto

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? U.S. Bacilli found.

(Signed) Joseph D. Lander M. D.

. 19 (Address) 1908 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park | DATE OF BURIAL, Mch 31 1924

20-UNDERTAKER, John A. Mitchell | ADDRESS 1201 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85425

CERTIFICATE OF DEATH.

100-001 ✓

D 85425

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2242 Wilkens Avenue St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Arthur Kennedy

(a) Residence No. 2242 Wilkens Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 2, 1886

7-AGE.	If LESS than 1 day,
37 yrs. 5 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Conductor on

(b) General nature of Industry, business, or establishment in which employed (or employer). B&O Railroad

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Daniel Edward Kennedy

11-BIRTHPLACE OF FATHER (city or town). Baltimore
(State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Gussie E. Stier

13-BIRTHPLACE OF MOTHER (city or town). Baltimore
(State or Country). Maryland

11- (Informant). Daniel Edward Kennedy

(Address). 2242 Wilkens Ave.

MAR 31 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 27, 1924 to March 28, 1924

that I last saw him alive on March 28, 1924

and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C. Kitch M. D.

3-28, 1924 (Address) 2151 Wilkens Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Mar 31, 1924
UNDERTAKER. Joseph B. Cook	ADDRESS 1003 W. Baltimore

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 85426

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 525 S. Luzerne Ave., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Boyer

(a) Residence No. 525 S. Luzerne Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: James F. Boyer

6-DATE OF BIRTH (month, day and year): Mar 25, 1847

7-AGE: 77 yrs. 0 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS

10-NAME OF FATHER: John Boyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-Informant: Mrs. William Porsinger

(Address) 524 S. Streeper St.

15-

MAR 31 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mar 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March 25 19 24 to March 29 19 24

that I last saw her alive on 29 19 24

and that death occurred, on the date stated above, at 12 00 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 5 days

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) 3 days

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical sign

(Signed) C. D. Heer M. D

3/30/24 19 (Address) 40 & Clifford

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: April 1, 1924

20-UNDERTAKER: H. Sander & Sons

ADDRESS: 1710 Fleet St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Joseph T. Hering

D 85427

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 85427

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Walbert Apartment 12 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Hering

(a) RESIDENCE NO. Walbert apt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Janette S Hering

6 DATE OF BIRTH (month, day, and year) May 3 64

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joshua McHering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Trumbo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Janette Hering
(Address) Walbert Apt

MAR 31 1924

ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

Duration (duration) yrs. mos. ds.

(Signed) W. J. Riley, M. D.
(Coroner.)

March 30, 1924 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — DATE OF BURIAL March 31 1924

20 UNDERTAKER W M Routson — ADDRESS 2235 N Mth

MENTION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85428

CERTIFICATE OF DEATH

1446 D 85428

1-PLACE OF DEATH Hospital for the Women of Maryland

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette & John ST. 8 WARD)

2-FULL NAME Mrs C Blanche Milbourne

(a) RESIDENCE NO. 1806 N. Port ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William E Milbourne

6 DATE OF BIRTH (month, day, and year) Dec 26 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	41	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Not Known

12 MAIDEN NAME OF MOTHER Ella Francis

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Mrs E Milbourne (Husband)

(Address) 1806 N. Port St

ROBERT R. KRAUTER,

MAR 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 23, 1924, to March 30, 1924,

that I last saw her alive on March 30, 1924,

and that death occurred, on the date stated above, at 9.08 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal infection

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary anemia - Chronic Abortion

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Mar. 25-1924

Was there an autopsy? Partial (abdominal + Thoracic)

What test confirmed diagnosis? Physical exam - Operation Autopsy

(Signed) J Clagett Warfield, Jr. M. D.

19 (Address) Woman's Hospital - Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 2 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

(over)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Haymon

D 85429

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 32 ✓ D 85429

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola Haymon

(a) RESIDENCE NO. Washington & Easton ST., WARD Easton Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19-1906

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
18	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) Hackman
(State or country) Delaware

PARENTS

10 NAME OF FATHER J. Wm C. Haymond

11 BIRTHPLACE OF FATHER (city or town) Bridgeville
(State or country) Delware

12 MAIDEN NAME OF MOTHER Emma Satterfield

13 BIRTHPLACE OF MOTHER (city or town) Burrsville
(State or country) Caroline Co. Md

14 Informant University Hospital
(Address) Lombard & Green

15 Filed MAR 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17

I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to March 29, 1924,

that I last saw h[illegible] alive on March 29, 1924,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 17 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical & Lab. findings.

(Signed) James Corbett M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wesley M. E. Cemetery Burrsville	Mar 31 1924
20 UNDERTAKER	ADDRESS
Chas C. Miller	2334 Jeffer[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE SHOULD BE FILLED OUT COMPLETELY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85430

CERTIFICATE OF DEATH.

109-602

D 85430

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Keene Av. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Muriel Anderson

(Residence in Baltimore: No. 2126 Clifton Av. St.; 4 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F.	W.	Single

6-DATE OF BIRTH, June 16, 1915
(Month) (Day) (Year)

7-AGE, 8 yrs. 7 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.!

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Chicago Ill.

PARENTS.

10-NAME OF FATHER, Elias P. Anderson

11-BIRTHPLACE OF FATHER (State or Country), Chicago Ill.

12-MAIDEN NAME OF MOTHER Bessie E. Larson

13-BIRTHPLACE OF MOTHER (State or Country), Norway

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elias P. Anderson

(Address) 2126 Clifton Ave

15- MAR 31 1924 ROBERT R. KRAUTER, 191..... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. 30, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 1 1924, to Mch 30 1924, that I saw h er alive on Mch 30 1924, and that death occurred, on the date stated above, at 7 55 m.

The CAUSE OF DEATH* was as follows:

Sinus Sarcoma Acute

(Duration).....yrs.....mos. 2 8 ds.

CONTRIBUTORY (Secondary) Sarcomatosis

(Duration).....yrs.....mos. 1 0 ds.

(Signed) Jacob Frahm M. D.

3/31/24 191... (Address) 1822 N. Wash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Chicago Ill.	Apl. 1, 1924
20-UNDERTAKER	ADDRESS
Wm Cook	2012 Nortka

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85431

CERTIFICATE OF DEATH.

59.00

D 85431

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Reese ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Virginia Jones

(a) RESIDENCE NO. 2809 Reese ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 23 '24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Albert R. Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) West Va

12 MAIDEN NAME OF MOTHER Lillian M Brent

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Albert R. Jones
(Address) 2809 Reese St

15 Filed MAR 31 1924 ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to March 29, 1924,

that I last saw h[illegible] alive on March 29, 1924

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Abscess

Pneumonia Double not Stated

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Fair M. D.

, 19 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary-Hampdon	March 31 1924
20 UNDERTAKER	ADDRESS
George J. Ruth.	1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85432

HEALTH DEPARTMENT—CITY OF BALTIMORE

131 D 85432

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital (ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catherine Lefkowicks

(a) RESIDENCE No. 418 E. Biddle St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Lefkowitz

6 DATE OF BIRTH (month, day, and year) May. 12 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas McGarvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lyeland.

14 Informant Adolph Lefkowitz (Address) 418 E. Biddle st

15 MAR 31 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to March 29, 1924, that I last saw her alive on March 29, 1924, and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis (Left).

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of March 23, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) B. M. Rhodes M. D.

19 (Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catholic Cemetery	April 1 1924
20 UNDERTAKER	ADDRESS
George J. Ruth	1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85433

CERTIFICATE OF DEATH.

D 85433
Registered No. C.....

1-PLACE OF DEATH: Near

City of BALTIMORE: (No. Washington Rd nr Wolfe St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Randolph Daily

(Residence in Baltimore: No. 26 Atlantic Ave nr Wolfe St. Yrs. 50 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: unknown ..... 1..... (Month) (Day) (Year)

7-AGE: 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Pier 4 Shed

9-BIRTHPLACE, (State or Country): Howard Co

PARENTS.

10-NAME OF FATHER: Daily

11-BIRTHPLACE OF FATHER, (State or Country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Garrett

(Address) 33 Warner St unknown

15.

MAR 31 1924 ROBERT R. KRAUTER, M.D. Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to Investigation death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull & suffocation by sand bank falling on Edge of Street on head

Instantly Stone (Duration) ..... yrs. Sudden ds.

CONTRIBUTORY (Secondary) Accident

.....(Duration)..... yrs. 2 mos. ..... ds.

(Signed) James M Fenton M. D. (Coroner.)

Mar 31 1924 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Mt Auburn Cemy Mar 31, 1924

20-UNDERTAKER. ADDRESS
Chas G H Hofer 406 N. Conway St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85434

CERTIFICATE OF DEATH.

X 101-001 ✓ D 85434

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 N. Mount ST., 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Hill

(a) RESIDENCE NO. 320 N. Mount ST., ... WARD Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Phillip Hill

11 BIRTHPLACE OF FATHER (city or town) Guilford (State or country) N.C.

12 MAIDEN NAME OF MOTHER Matilda Hill

13 BIRTHPLACE OF MOTHER (city or town) Guilford (State or country) N.C.

14 Informant Chas. Thompson.

(Address) 220 N. Mount St.

MAR 31 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1924, to Mar. 28, 1924.

that I last saw him alive on Mar. 28, 1924,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis (Interstitial)

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Urbana Ohio.	3/31/24.

20 UNDERTAKER Samuel Hensley & Bro. ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85435

CERTIFICATE OF DEATH.

101-001 D 85435

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Granby st ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alberto Pavone

(Residence in Baltimore: No. 1011 Granby st St.; ....yrs. 8 mos. 24 da.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male | 4-COLOR OR RACE, white | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, July 6 (Month) (Day), 1915 (Year)

7-AGE, ...yrs. 8 mos. 24 da. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Fiore Pavone

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosina Donato

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Flora Pavone

(Address) 1011 Granby St

15- MAR 31 1924 ROBERT N. KRAUTER Burial Permit Clerk. 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 30 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 29 1924, to March 30 1924, that I saw h[im] alive on March 30 1924, and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Clear Pneumonia

.....

.....

..... (Duration) ....yrs. ....mos. 3 da.

CONTRIBUTORY (Secondary).....

..... (Duration) ....yrs. ....mos. ....da.

(Signed) Chas. Sedita M. D.

....., 191... (Address) 710 Pearl St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer | DATE OF BURIAL, April 1, 1924

20-UNDERTAKER William J. Schaffer | ADDRESS 1816 Monument St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85436

CERTIFICATE OF DEATH.

1 D 85436

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 19 WARD)

2-FULL NAME Annie A. Esterley

(a) RESIDENCE NO. 1532 Hollins St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Esterley

6 DATE OF BIRTH (month, day, and year) July 6, 1865

7 AGE	Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
	58	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Heinbuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Geblein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant James A. Esterley

(Address) 1532 Hollins St

15 MAR 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1924, to March 30, 1924, that I last saw her alive on March 30, 1924, and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis

..... (duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

..... (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore City.

Did an operation precede death? Yes Date of March 28, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald E Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	April 2 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85437.

CERTIFICATE OF DEATH.

109-00 D 85437.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 603 S. Clinton ST., 76 WARD)

2-FULL NAME Charlotte H. Jones.

(a) RESIDENCE NO. 603 S. Clinton St. ST., 76 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward L. Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary C. Krug

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary C. Jones.
(Address) 603 S. Clinton St.

15 MAR 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to Mar. 29, 1924, that I last saw her alive on Mar. 28, 1924, and that death occurred, on the date stated above, at 4.35 a. m.

The CAUSE OF DEATH* was as follows:

Streptococcus sore throat.

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) J. H. McConnell, M. D.

(Address) 633-5 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Mch 31 1924
20 UNDERTAKER Lilly and Zuler	ADDRESS 403 S. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D 85438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85438

CERTIFICATE OF DEATH.

1627

REGISTERED NO. .....

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (NO. 6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Frank

(a) RESIDENCE NO. 19 N Ann ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 29 1924

7 AGE — Years — Months — Days — If LESS than 1 day, 24 hrs. 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Frank

11 BIRTHPLACE OF FATHER (city or town) Russia.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Bumand

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant (Address) Hosp Records

ROBERT R. KRAUTER,
Burial Permit Clerk.

MAR 31 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1924, to March 30, 1924

that I last saw h living on March 30, 1924

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia (cause unknown)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Isidor D. Fry, M. D.

Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Hebrew Rin

DATE OF BURIAL 3/31/1924

20 UNDERTAKER Jack Levis 1439 E Balto St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS PAPER BECOMES A PERMANENT RECORD. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85439 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85439

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 N. Madeira St. WARD)

2-FULL NAME Paul D. Wright

(a) RESIDENCE NO. 125 N. Madeira St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
male	colord	married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Fayetteville N.C.

9 BIRTHPLACE (city or town) Fayetteville N.C.
(State or country)

PARENTS

10 NAME OF FATHER William Wright

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country) Fayetteville

12 MAIDEN NAME OF MOTHER Anna M. Brown

13 BIRTHPLACE OF MOTHER (city or town) N.C.
(State or country)

14 Informant Lorena Wright
(Address) W. Madeira St 125

Filed MAR 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924, to March 29, 1924.

that I last saw him alive on March 29, 1924.

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) S. W. Kinney, M. D.

, 19 (Address) 1912 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury cemetery

DATE OF BURIAL March 31 1924

20 UNDERTAKER Edward Bryson

ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85440

D 85440

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S. Dallas ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Stafford

(a) RESIDENCE NO. 413 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Stafford

6 DATE OF BIRTH (month, day, and year) April 23/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Co
(c) Name of employer

9 BIRTHPLACE (city or town) Eastern Shore
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Annie Stafford
(Address) 413 S. Dallas St

15 Filed MAR 31 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Distanded stomach-indigestion (duration) yrs. mos. ds.

(Signed) [signature], M. D.
(Coroner.)

Mar 31/24 (Address) 508 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL Mar 31 1924

20 UNDERTAKER [signature] ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85441

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 85441

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Sherwood

(a) Residence No. 1021 Pennsylvania St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1875

7-AGE.	If LESS than 1 day.
49 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Sam Sherwood

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

11- (Informant) Municipal Hospital Records

(Address)

MAR 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-28-24

17- I HEREBY CERTIFY, That I attended deceased from 3-21, 1924 to 3-28, 1924

that I last saw him alive on 3-27, 1924

and that death occurred, on the date stated above, at 1:45 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis; Syphilitic Aortitis; aortic insufficiency; Myocardial degeneration

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude S. Brown M. D.

3-28, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Easton Md	3-31, 1924
20-UNDERTAKER, David Easton	ADDRESS 916 Baltimore

N. B.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Clarence Chambers

D 85442 HEALTH DEPARTMENT—CITY OF BALTIMORE 84 D 85442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1621 N. Bruce St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Clarence Chambers

(a) Residence No. 1621 N. Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 6 1907

7-AGE,	If LESS than 1 day,
17 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) (State or Country) Balto City Md

PARENTS.

10-NAME OF FATHER. Charles A Chambers

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER. Sadie Hackett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Charles A Chambers

(Address) 1621 N. Bruce St.

15- MAR 31 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 30 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1, 19 24, to March 30, 19 24, that I last saw h— alive on March 24, 19 24 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pyogenic Infection of Left Temporal Lobe of Brain.

over

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebellum

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Charles E Brantley M. D.

March 31 1924 (Address) 817 Stump St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel Cem	4-1-, 19 24
20-UNDERTAKER,	ADDRESS
David Easter	916 Park Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35443

CERTIFICATE OF DEATH.

D 85443

1-PLACE OF DEATH.

City of BALTIMORE: (No. 326 N. Arlington St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William Gould

(a) Residence No..... 326 N. Arlington St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE, 60 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer OLD

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER John Gould

11-BIRTHPLACE OF FATHER (city or town) (State or Country) MD

12-MAIDEN NAME OF MOTHER Mary Gibson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) MD

14- (Informant) Mary Gould

(Address) 326 N. Arlington St.

15- Filed MAR 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924, to March 29, 1924 that I last saw h— alive on March 20, 1924 and that death occurred, on the date stated above, at 5.20 P. m. The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 29 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. 29 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles B. Fowler M. D.

March 29 1924 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	April 1 1924
20-UNDERTAKER. David Carter	ADDRESS 96 Saratoga

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85444

D 85444

CERTIFICATE OF DEATH.

REGISTERED NO. 15-21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 527 Cumberland ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Goggin.

(a) RESIDENCE. No. 527 Cumberland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dr. Wm W. Goggin

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
(78)	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None MD

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ireland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Edwd Meyers
(Address) 527. Cumberland

15 Filed MAR 31 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924, to March 29, 1924.

that I last saw h[illegible] alive on March 25, 1924.

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocarditis -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) F. B. Sumner, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 4-1-24

20 UNDERTAKER: H. C. Brannigan Son

ADDRESS 517 N Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Blanks should be stated EXACTLY. PHYSICIANS' mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85445

CERTIFICATE OF DEATH.

D 85445

1-PLACE OF DEATH 1839 Ausquith St 9 12 REGISTERED NO. C

CITY OF BALTIMORE: (No. ..... ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Miles

(Residence in Baltimore: No. 1839 Ausquith St. St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, November (Month) 24 (Day), 1885 (Year)

7-AGE, 39 yrs. 4 mos. 6 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Trimmer for
(b) General nature of industry, business, or establishment in which employed (or employer) ..... for Straw hats

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Bernard Jos. Miles

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Conners

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nellie Miles

(Address) 1839 Ausquith St.

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

APR 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 3 (Month) 30 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar 24 1924, to Mar 30 1924, that I saw her alive on Mar. 30. 1924, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial
Nephritis
orn

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Uremic Coma

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Mary F. Vaughan M. D.

Mar 31., 1924. (Address) 1028 Valley St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, April 2., 1924

20-UNDERTAKER Josiah Lyter — ADDRESS 160 W North Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85446

CERTIFICATE OF DEATH.

124 D 85446

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 16 WARD)

2-FULL NAME Mary K Klingelhofer

(a) RESIDENCE NO. 1005 W Lafayette Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Klingelhofer

6 DATE OF BIRTH (month, day, and year) 27 Aug 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Loos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U/

14 Informant (Address) Hospital Records. Mt Berry Ga 2422 Woodbrook

15 Filed MAR 31 1924, 19 Robert P. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1927, to March 29, 1924, that I last saw her alive on March 29, 1924, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Infarct

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/21/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. J. Clyde, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 31st 1924
20 UNDERTAKER	ADDRESS
Josiah Sapper	1600 Warwick Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35447

CERTIFICATE OF DEATH

46 D 35447

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 626 W. 36 St. ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Briscoe

(a) RESIDENCE NO. 626 W. 36 ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 4 ds. How long in U. S., If of foreign birth? 48 yrs. 6 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew E. Briscoe

6 DATE OF BIRTH (month, day, and year) July 27 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48.	6.	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER George R. Stalk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E. Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Andrew E. Briscoe (Address) 626 W. 36 St.

Filed MAR 31 1924, 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. ..., 1923, to March 31, 1924, that I last saw her alive on March 31, 1924, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus, Bladder & Rectum

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Operation & Lab. Exam.

(Signed) Frank H. Bradshaw, M. D.

3/31, 1924 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	4/2 1924
20 UNDERTAKER J. Walter Davis.	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85448

CERTIFICATE OF DEATH.

31 D 85448

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J. Kerns

(a) RESIDENCE NO. Mt Hope Retreat ST., 28 WARD (Resident.)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
Colored	51	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spinner

(b) General nature of industry, business, or establishment in which employed (or employer) Cotton factory

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dickeyville Md

PARENTS

10 NAME OF FATHER John Kerns.

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Ireland

12 MAIDEN NAME OF MOTHER Hannah Lilly.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Della Md.

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Md

15 Filed 1924 Robert F. Harrison, Registrar

Burial permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1924

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1906, to March 31st, 1924, that I last saw him alive on March 20, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chr Pulm Intestinal Tuberculosis.

Colored (duration) 5 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Chr. Mania. Colored (duration) 17 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Dickeyville Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

March 31st 1924 (Address) Mt Hope Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL April 1 1924

20 UNDERTAKER WILLIAM F. WOODEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

CAUTION—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 85449

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Fleet ST., V WARD)

2-FULL NAME Rose John

(a) RESIDENCE NO. 1728 Fleet ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Friedrich, John

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER Knevell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josphine Bezzenzahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martin W E Dobler (Address) 1720 Linden Ave

15 MAR 31 1924, 19.... Registrar Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1923, to Mar. 30, 1924.

that I last saw h.. alive on Mar. 27, 1924,

and that death occurred, on the date stated above, at 8 00 1/2 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine, (dorsal region)

(duration) 7 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) General miliary Tuberculosis

(duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas H Mastodt, M. D.

19 (Address) 1730 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lehwalt	April 2nd 24
20 UNDERTAKER	ADDRESS
Wendell Wyffel & Son	3181 N

Buried Forest Park

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85450

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH St Agnes Hosp

City of BALTIMORE: (No. ..... St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Dorothy M Lebo

(a) Residence No. 1812 W Lexington St St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F emale

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the Word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) July 7 1909

7-AGE 14 yrs. 8 mos. 23 ds.

If LESS than 1 day ..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Harpers Ferry

(State or Country) West Va

PARENTS.

10-NAME OF FATHER Elmer E Lebo.

11-BIRTHPLACE OF FATHER (City or town) Martinsburg

(State or Country) West Va

12-MAIDEN NAME OF MOTHER Mary Segal.

13-BIRTHPLACE OF MOTHER (City or town) Baltimore

(State or Country) Md

14- (Informant) Mr. E E Lebo.

(Address) 1812 W. Lexington St

15- Filed MAR 31 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from 3/27/24 19 ..... to 3/30/24 19 .....

that I last saw her alive on 3/30/24 19 .....

and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Ac Appendicitis

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/27/24

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) H U Harper M. D

3-31, 1924 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Apr. 2" 1924

20-UNDERTAKER Joseph B Cook

ADDRESS 1003 W Baltimore St

Stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85451

CERTIFICATE OF DEATH.

D 85451

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Edmondson Ave St. 20 WARD)

2-FULL NAME Edwin Robert Hodson

(a) RESIDENCE NO. 2313 Edmondson Ave St. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Martha A Hodson.

6 DATE OF BIRTH (month, day, and year) Dec 9 - 1852.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	71	3	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician & Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

054

9 BIRTHPLACE (city or town) Anne Arundel Co.,
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert Hodson

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Julia Sheckels

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) Maryland.

14 Informant (Address) Martha A. Hodson 2313 Edmondson Ave,

15 Robert P. Harrison, Registrar

MAR 31 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1924, to March 31, 1924, that I last saw him alive on March 30, 1924, and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of upper part of Duodenum and pylorus.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs

(Signed) Chester Riland., M. D.

3-31-1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	April 2 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Eutaw Ave,

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks. Mary Blum

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85452

CERTIFICATE OF DEATH.

6 74-08

D 85452

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 N. Washington ST., 6 WARD)

2-FULL NAME Mary Blum (Blum)

(a) RESIDENCE NO. 204 N Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Blum (Blum)

6 DATE OF BIRTH (month, day, and year) Aug 12 22 /1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant Mrs. R. F. Coggins
(Address) ~~507 N. Collington Ave~~

15 Filed MAR 31 1924 Robert P. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Senile)

(duration) yrs. mos. ds.

(Signed) J S H Waters, M. D.
(Coroner.)

Mar 31/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Apr 1 1924

ADDRESS 2008 Alsop

20 UNDERTAKER John Ellerick

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AR 31 1924

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85453

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85453

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 423 N Castle St., 6 Ward) Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank C. Barrack

(a) Residence No. 723 N Castle St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Alice Taylor

6-DATE OF BIRTH (month, day and year): 4/19/1895

7-AGE	If LESS than 1 day,
28 yrs. 11 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Covington Va

9-BIRTHPLACE (city or town) (State or Country),

PARENTS:
10-NAME OF FATHER: Henry F. Barrack
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va
12-MAIDEN NAME OF MOTHER: Mary Helen
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Alice Barrack
(Address) 723 N Castle St

15- Robert P. Harrison, Registrar.

MAR 31 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3/28/24

17- I HEREBY CERTIFY, That I attended deceased from Mar 26 1924 to Mar 28 1924

that I last saw him alive on Mar 28 1924

and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) Geo Clinton Bladen M. D.

3/29/1924 (Address) 143 N Kenay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	Apr 3, 1924
20-UNDERTAKER. John Wells & Co	ADDRESS 2008 Eutaw

INSTRUCTIONS.—WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85454

CERTIFICATE OF DEATH.

D 85454

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Cor. Jarbard & Greene ST., 17 WARD)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Dyson

(a) RESIDENCE No. 574 Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Robert Dyson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Boston Asbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Univ. Hosp. Records (Address)

APR 1 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 23, 1924, to Mar 30, 1924, that I last saw her alive on Mar 30, 1924, and that death occurred, on the date stated above, at 11.20 p.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

Myocardial Insufficiency

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of Mar. 25, 1924

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Operative findings

(Signed) David R. Newcomer, M. D.

Mar 26 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-1-1924
20 UNDERTAKER	ADDRESS
David Easton	916 Cathedral

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 35455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 35455

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1647 Balt St. ST. 24. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh E. Kyle.

(a) RESIDENCE. No. 1647 Balt St. ST., 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie V. Kyle.

6 DATE OF BIRTH (month, day, and year) June, 24, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60,	9,	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caller, B. & O. 13 01

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER Willian Kyle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Nancy Scottan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Lillie V. Kyle. (Wife).

(Address) 1647 Balt St.

15 Filed APR 1 - 1924, 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1924 to Mar. 30, 1924, that I last saw him alive on Mar. 29, 1924, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. F. Hartman, M. D.

Mar. 31, 1924 (Address) 1 E Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Silver Brook Cem. Wilmington Del.	April 2 1924

20 UNDERTAKER A Howard Evans ADDRESS 38 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 85456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N. Central Avenue ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Wolf

(a) RESIDENCE NO. 205 N. Central Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Wolf

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wolf Kretstine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto.

15 APR 1 - 1924 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

(Signed) J. S. Pallen, M. D.
(Coroner.)

3-31, 1924 (Address) 508 E. North Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Rosedale — DATE OF BURIAL 4-1- 1924

20 UNDERTAKER Jack Lewis, — ADDRESS 1439 E. Balto

DATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

D 85457

CERTIFICATE OF DEATH.

D 85457.

1-PLACE OF DEATH Hebrew Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Levin

(a) RESIDENCE NO. 1641 N. Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced · HUSBAND of (or) WIFE of ..... Child

6 DATE OF BIRTH (month, day, and year) Dec 1-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Charles Levin

11 BIRTHPLACE OF FATHER (city or town) Balto, Md. (State or country)

12 MAIDEN NAME OF MOTHER Anna Pearl

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md. (State or country)

14 Informant (Address) L. Levin 1439 E. Balto St.

15 Filed APR 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to March 31, 1924, that I last saw h w alive on March 31, 1924, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary) (duration) 3 days.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & lab.

(Signed) Isidore S. Frey, M. D.

Mar. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash. Road — DATE OF BURIAL 4-1924

20 UNDERTAKER for Levin — ADDRESS 1439 E. Balto

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85458

CERTIFICATE OF DEATH.

113 ✓ D 85458

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

2-FULL NAME Ernest King Soane

(a) RESIDENCE NO. 716 Evesham Ave. ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Baby

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Son

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) .....

PARENTS

10 NAME OF FATHER Isaac Soane.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Genevieve Sessions

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed APR 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1924, to April 1, 1924, that I last saw him alive on April 1, 1924, and that death occurred, on the date stated above, at 3 50 A m.

The CAUSE OF DEATH* was as follows:

Malnutrition — Life 8 ds.
Diarrhea (not dysentery)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) X
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) A. R. Wreath, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	4/2 1924
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	1810 N. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85459

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Lawrence St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Douglass

(a) Residence No. 412 Lawrence St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Fe

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Douglass

6-DATE OF BIRTH (month, day and year) 1863

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Edward Douglass

(Address) 412 Lawrence St

15- Filed APR 1 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 31. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 22, 1924, to March 31, 1924

that I last saw h... alive on March 24, 1924

and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. G. Churchill M. D.

March 31, 1924 (Address) 1334 E. Pratt

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL, March 31, 1924

20-UNDERTAKER Sam'l W. Craig & Son ADDRESS 1400 Madison

N. B.—WHITE PAPER, WITH ONE CARBON LINE. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85460

CERTIFICATE OF DEATH.

161-001 ✓ D 85460

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Flora Williams

(a) RESIDENCE NO. 622 Dolphin St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 21/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jerome Williams

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Flora Demby

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Francis Davis
(Address) 1843 N. Spring St

15 Filed APR 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity - 7 mons gestation

(Autopsy at Hopkins Hosp.)

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hatten, M. D.
(Coroner.)

Mar 31/1924 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	April 1924
20 UNDERTAKER Sam'l Grace & Son	ADDRESS Pikesville

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Wheeler

85461

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 85461

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Eliny ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia V. Wheeler

(a) RESIDENCE NO. 1201 Eliny ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer Bd. of Sch. Com'rs

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lillian Thomas

(Address) 1201 Eliny St.

Filed APR 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/24

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13th, 1924, to March 24, 1924, that I last saw h— alive on March 24th, 1924, and that death occurred, on the date stated above, at 1.12 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-Chronic Brights disease

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Organic Stomach Dis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Co. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Ellis, M. D.

19 24 (Address) 324 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	3/27/ 1924
20 UNDERTAKER	ADDRESS
Sam'l H. Chase & Son	1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85462

D 85462

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 Mc Comas St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Richard Arnold

(a) Residence No. 209 Mc Comas St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Arnold

6-DATE OF BIRTH (month, day and year) Jan. 10 1850

7-AGE.	If LESS than 1 day,
74 yrs. 2 mos. 20 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. John Arnold

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Lawrence Arnold

(Address) 209 Mc Comas St

15- Filed APR 1 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 30/24

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1924 to Mar 30 1924

that I last saw h[illegible]live on Mar 30 1924

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Indefinate

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

Mar 31, 1924 (Address) 1644 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Jones A.A. Co. Md.	4/1 1924
20-UNDERTAKER.	**ADDRESS**
J. Fenw McCully	130 E. Fort.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—MAT—1500 Bks.

D 85463

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85463

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 423 W Mulberry ST., 23 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Frome

(a) RESIDENCE NO. 423 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Frome

6 DATE OF BIRTH (month, day, and year) March 20 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Herman W. Frome

(Address) 1721 Montpelier St.

Filed APR 1 - 1924 19

R. KRAUTER Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to March 31, 1924

that I last saw h[illegible] alive on March 30, 1924

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinically

(Signed) R. S. Campbell M. D.

1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 4/2 1924

20 UNDERTAKER J. F. McCully

ADDRESS 130 E Front

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1 10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85464

CERTIFICATE OF DEATH.

X10 D 85464

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE—(No. Sydenham Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bohm

(a) RESIDENCE No. Millersville, Anne Arundel Co - Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	21	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pasadena, md.

PARENTS

10 NAME OF FATHER Chas. Bohm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elena Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Sydenham Hospital

15 APR 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1924, to March 30, 1924, that I last saw living on March 30, 1924, and that death occurred, on the date stated above, at 10:25 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar + pharyngeal

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism (?) acute myocarditis.

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B Blackman M.D. M. D.

4/1/24 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 1 1924
20 UNDERTAKER John F Denny	ADDRESS 915 Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85465

CERTIFICATE OF DEATH.

D 85465

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 75 WARD)

2-FULL NAME Elliott Hunt.

(a) RESIDENCE NO. 9 a of Fairfield Md. ST., WARD S. 6.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Hunt

6 DATE OF BIRTH (month, day, and year) Sept 20-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer do

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) South Carolina

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ellen Hunt. (Address) 1224 - 9 at Fairfield

15 Filed APR 1 - 1924 ROBERT R. KRESSY Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1924, to March 29, 1924, that I last saw him alive on March 29, 1924, and that death occurred, on the date stated above, at 4:45 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Appendicitis.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes - Date of 3/28/24

Was there an autopsy? No.

What test confirmed diagnosis? P.M.E. & Sputum

(Signed) Harold E. Gilbert M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenville So. Carolina	4-2 1924
20 UNDERTAKER George T. A. Lebon	ADDRESS 1725 Linden Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85466

CERTIFICATE OF DEATH.

X 188-003 ✓

D 85466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., [illegible] WARD)

2-FULL NAME Hugh K. Paulter

(a) RESIDENCE NO. Ellicott city ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work State Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer State Md 061

9 BIRTHPLACE (city or town) Dont Know
(State or country)

PARENTS

10 NAME OF FATHER Sedney Paulter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Arizona

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) L C
(State or country)

14 Informant Mrs H. K. Paulter
(Address) 62 W 55th St Baltimore

15 APR 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia,

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Aqueduct from Town
(duration) yrs. mos. ds.

(Signed) H K Gorsuch, M. D.
(Coroner.)

4-1, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Haven Conn P.R.R. DATE OF BURIAL Apr 1 1924

20 UNDERTAKER John F Denny ADDRESS 715 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85467 ✓ D 85467

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Coy

(a) RESIDENCE NO. Bear Hills Ext Woodington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	M.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12—1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58.	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic 037

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Shaw

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Frisky

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Arizona Jenkins
(Address) Baltimore Md

FILED APR 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17 I HEREBY CERTIFY, That I attended deceased from January 27, 1924, to March 30, 1924, that I last saw h[illegible] alive on March 30, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Schmunk, M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 4-2 1924

20 UNDERTAKER George T. A. Gibson

ADDRESS 1733 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85468

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gaspero Namio

(a) RESIDENCE NO. 2402 Lauretta Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State) New York.

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosalia Biddeci Namio

6 DATE OF BIRTH (month, day, and year) Nov 13/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Namio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Periz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosalia B. Namio
(Address) 2916 Weaver Ave

15 APR 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide- Pistol wounds in chest. (Inquest to be held Apr. 1/24

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Watts, M. D.
(Coroner.)

Mar 31/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent Cemetery.

DATE OF BURIAL [illegible] 1924

20 UNDERTAKER Geo. - f. Ruth

ADDRESS 17[illegible] Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85469 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D 85469

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1505 Clarkson St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Lanahan

(a) Residence No. 1505 Clarkson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara V Lanahan

6-DATE OF BIRTH (month, day and year) Dec 23 1865

7-AGE. 58 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Contractor

(b) General nature of industry, business, or establishment in which employed (or employer). Boat building

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER Cornelius Lanahan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER Mary Doyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Clara V Lanahan

(Address) 1505 Clarkson

15- Filed APR 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar 30/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 21 1924 to Mar 30 1924

that I last saw h~~e~~ alive on Mar 30 1924

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Bright's Disease (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R R Campbell M. D

Apl 1 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem — DATE OF BURIAL. April 1, 1924

20-UNDERTAKER. Wm J Turner Sons — ADDRESS North & Pa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3142 Remington ave

D 85470 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85470

CERTIFICATE OF DEATH. 90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3142 Remington ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew C. Boone

(Residence in Baltimore: No. 3142 Remington ave St.; yrs., Lifetimes.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, March (Month) 30 (Day) 1864 (Year)

7-AGE, 62 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Pattern
(b) General nature of industry, business, or establishment in which employed (or employer) Maker

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm C. Boone

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Agnes B. Morrisey

13-BIRTHPLACE OF MOTHER, (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes C. Boone

(Address) 3142 Remington ave

15-

Filed APR 1 - 1924 19

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 30 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas J. Morrisey M. D. (Coroner.)

1924 (Address) 3682 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery DATE OF BURIAL, April 2 1924

20-UNDERTAKER, Chas J. Emerson ADDRESS 1181 Mt. Royal ave

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSE is very important. See Instructions on back of certificate.

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85471

CERTIFICATE OF DEATH.

31 D 85471

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 N. Collington Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... J. Hubert Slimmer

(a) Residence No. 1518 N. Collington ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 27-1895

7-AGE. 28 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Electrican
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. James E. Slimmer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Rose M. Dunkin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- Informant. Rose M. Slimmer
(Address) 1518 N. Collington ave

15- Filed APR 1 1924 192.....
Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 30-1924

17- I HEREBY CERTIFY, That I attended deceased from June 14 1923 to Mar 30 1924

that I last saw h.. alive on Mar 30 1924

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum & X Ray

(Signed) L. Pudagliacco M. D.

19 (Address) 37 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 4/3, 1924
Cathedral Cem	
20-UNDERTAKER. Chas. E. Evans & Son	ADDRESS 11 & 13 W. Royal ave

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85472

CERTIFICATE OF DEATH.

D 85472

1-PLACE OF DEATH Oak Court apt

CITY OF BALTIMORE: (No. Walbrook Ave + Windsor Mill Rd. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Donald Jones Jr

(a) RESIDENCE NO. Walbrook Ave + Windsor Mill Rd ST., WARD Cambridge Md.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS
10 NAME OF FATHER Arthur D. Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md
12 MAIDEN NAME OF MOTHER Sophie L. Kirwan
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge

14 Informant Arthur D. Jones
(Address) Cambridge Md

15 APR 1 Filed 1924. Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1/1924 19

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1924. to Apr 1, 1924.
that I last saw him alive on Apr 1, 1924,
and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

acute splenic myelogenic Leukemia
(primary anemia)

(duration) yrs. 7 mos. 13 ds.

CONTRIBUTORY (Secondary) Acute Splenic-myelogenic Leukemia
(duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Lab. examination

(Signed) Hall & Hublitt, M. D.

Apr 1/24 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cambridge Md

DATE OF BURIAL Apl 1 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1424 W. Northam

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

D 35473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85473

CERTIFICATE OF DEATH.

178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 E. Madison ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Vavrina

(a) RESIDENCE No. 22 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Vavrina

6 DATE OF BIRTH (month, day, and year) Sept. 2/1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Milskie

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Weyner

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa.

14 Informant Mrs. Theresa Gordon
(Address) 22 E. Madison

15 FEB 1 - 1924 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 19 24

17

I HEREBY CERTIFY, That I attended deceased from March 21 . 19 24. to March 29 . 19 24.

that I last saw h alive on March 29 . 19 24.

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

x Acute nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

x not purposely self-inflicted or accidental

(Signed) Stanley McKelvey, M. D.

. 19 (Address) 1609 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 1 1924

20 UNDERTAKER Jos. J. Iden 15 E. N.

ADDRESS Eutaw

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85474 ✓ D 85474

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1744 E. 25 st St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Makinson

(a) Residence No. 1744 E. 25 st St., Ward Wash. D. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late James Makinson

6-DATE OF BIRTH (month, day and year) Oct. 5-1847

7-AGE. 76 yrs. 5 mos. 26 ds. ~~If LESS than 1 day, ... hrs. or ... min.~~

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). England.

PARENTS.

10-NAME OF FATHER. James Richardson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England.

14-

(Informant) Agnes Makinson

(Address) 1744 E. 25 st.

15-

APR 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3-31-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 24 1924 to March 31 1924

that I last saw h.. alive on March 31 1924

and that death occurred, on the date stated above, at 1-45 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Natural Degeneration

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [illegible] M. D

, 19 (Address) 1506 [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Glenwood Cemetery Washington D.C. DATE OF BURIAL. April 2, 1924

20-UNDERTAKER. George F. Ruth ADDRESS 1735 Harford

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

18.—WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85475 ✓ D 85475

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME George Ellis

(a) RESIDENCE NO. 213 Maple St ST., ... WARD Marietta Ohio

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Oct 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John Ellas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address)

15 Robert P. Harrison, Registrar

APR 1 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1924, to March 31, 1924, that I last saw him alive on March 31, 1924, and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate.

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Pyelonephritis.

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Ohio. October - 1923

Did an operation precede death? yes. Date of Feb. 18 1924

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Winfield W. Scott, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vernon Ohio — DATE OF BURIAL Apr 1 1924

20 UNDERTAKER Wm E. Black — ADDRESS 927 N. Broadway

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Leiding)

17-516 mod 85476

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 32 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Leiding

(a) RESIDENCE No. 1420 S Patterson St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE OF~~) Nellie Leiding

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Window cleaner
(b) General nature of industry, business, or establishment in which employed (or employer) 186
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S C

PARENTS
10 NAME OF FATHER Herman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger
12 MAIDEN NAME OF MOTHER A. L. Young
13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 APR 1 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 19, 1924 to Mar 29, 1924
that I last saw him alive on Mar 29, 1924
and that death occurred, on the date stated above, at 7.50 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Balto.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) Walter B. Stewart, M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmell	4/1/1924
20 UNDERTAKER	ADDRESS
Joseph abrams	221 Bway

CAUTION—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85477. HEALTH DEPARTMENT—CITY OF BALTIMORE D 85477.

101-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Chesser

(a) RESIDENCE NO. 2212 E. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan. 8/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Chesser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Hilda LYELLA

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant John Chesser
(Address) 2212 E. Fayette St

15 Filed APR 1 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S H Callis, M. D.
(Coroner.)

Apr 1/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patrick Cemetery	April 2 1924
20 UNDERTAKER William J. Schaefer	ADDRESS 1816 Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Blks.

(Joseph Jaworski)

D 85478

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85478

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 96 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos Jaworskie

(a) RESIDENCE NO. 921 So. East ST., Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 10-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50 years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real estate.

(b) General nature of industry, business, or establishment in which employed (or employer) 071

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wojciech Jaworski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Hadwiga Dzaberska

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant John Jaworski (Address) 921 So. East Ave

15 Filed APR 1 -1924 Robert P. Harrison, Registrar

Burial permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 26th, 1924, to Mar 29th, 1924, that I last saw h in alive on Mar 29th, 1924, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Strept. infection right arm. (Arm)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocardial manif. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A C Monninger, M. D.

3-29. 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	4-2- 1924
20 UNDERTAKER	ADDRESS
Stephen J Kwiatkowski	10 S Eutaw

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85479

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85479

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 N. Gilmor St., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Evelyn Harry Watson

(a) RESIDENCE NO. 1106 N. Gilmor St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel Watson
(Address) 1106 N. Gilmor St.

15 Filed April 1, 1924 Robert P. Barrett Registrar

ABRT - 1924 Burl J. Pratt, Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 2 ds.

(Signed) J. J. T. Hennessy, M. D. (Coroner.)

(Address) 2802 Eutaw Pl. April 1, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	April 2nd 1924
20 UNDERTAKER A. Jones	ADDRESS 1118 Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85480

CERTIFICATE OF DEATH.

4/4 D 85480

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Carl Cort

CITY OF BALTIMORE: (No. Preston & St Paul ST., 11 WARD)

2-FULL NAME Mary Frances Taylor

(a) RESIDENCE NO. Preston & St Paul ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER L.T. Wigfall

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Charlotte Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant H L Clarke
(Address) Preston & St Paul St

15 APR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1924

17 I HEREBY CERTIFY, That I attended deceased from Feby 20th, 1924, to March 31st, 1924, that I last saw her alive on March 31st, 1924, and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (Greater curvature)

Known (duration) yrs. mos 40 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? X Ray &c

(Signed) Edw F Vandyke, M. D.

4.1, 1924 (Address) 1515 Pont ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forrest Lawn	April 2 1924
20 UNDERTAKER	ADDRESS
H H Jenkins & Son Co	Oakland Mt Hall Co

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85481

CERTIFICATE OF DEATH.

100-001

D 85481

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 College alley ST., 4 WARD)

2-FULL NAME Baby Newton

(a) RESIDENCE No. 314 College alley ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chield

6 DATE OF BIRTH (month, day, and year) Mar 28/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
✓			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer ..... —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Laura Neuton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) G Father Richard Newton 314 College Alley

15 Filed APR 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17

I HEREBY CERTIFY, That I attended deceased from March 28. 1924. to March 31. 1924.

that I last saw her alive on March 30. 1924.

and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

Exposure (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr L W Kennard M. D.

3-31. 1924 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85482

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 507 N. Chester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cyril J. Narratil

(a) Residence No. 507 N. Chester St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Antonina Narratil

6-DATE OF BIRTH (month, day and year) July 21-1870

7-AGE. 53 yrs. 8 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Near Alaska

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Near Alaska

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Near Alaska

14- (Informant) Miss Celia Narratil

(Address) 1920 N. Eden Ave

15- Received APR 2 - 1924 ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 30/1924

17- I HEREBY CERTIFY, That I attended deceased from 3-1, 1924 to 3-30 1924

that I last saw h alive on 3-30 1924

and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

acute Diffuse Nephritis

Hypertension

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

1924 (Address) 5009 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem

DATE OF BURIAL. Apr. 2 1924

20-UNDERTAKER. John Merritt

ADDRESS 500 Parkside

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3533 E Fairmount Ave St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Catherine Noonan)

(a) Residence No. 3533 E Fairmount St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Paul J Noonan

6-DATE OF BIRTH (month, day and year) June 28/1874

7-AGE. 49 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Long.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Julia Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Paul J Noonan

(Address) 3533 E Fairmount

15- APR 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 1-1924

17- I HEREBY CERTIFY, That I attended deceased from March 24 1924 to April 1 1924

that I last saw h.er alive on April 1 1924

and that death occurred, on the date stated above, at 2.9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P Artigiani M. D.

, 19 (Address) 29th & Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Carmel — DATE OF BURIAL, April 5, 1924

20-UNDERTAKER, John Ellicott — ADDRESS 208 N Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 85484

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard & Eighth St. ST., 13 WARD)

2-FULL NAME John J. F. Gorman

(a) RESIDENCE NO. 3561 Cedar Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary E. Gorman

6 DATE OF BIRTH (month, day, and year) Apr 30 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shop Forman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer United Elec Ry Co

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John Gorman

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Barnet

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Mary E. Gorman
(Address) 3561 Cedar Ave

15 Filed APR 2 - 1924 192.... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo Clinton Wades, M. D.
(Coroner.)

5/31/24, 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's	June 2 1924
20 UNDERTAKER A. S. Malshall 3539	ADDRESS Fallsrd

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 85485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3112 Dillon St. ST., 1 WARD)

2-FULL NAME Joseph Hawkins

(a) RESIDENCE NO. 3112 Dillon St ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Patrick Hawkins

11 BIRTHPLACE OF FATHER (city or town) New York. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Andrea

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Patrick Hawkins (Address) 3112 Dillon St.

15 Filed APR 2 - 1924 ROBERT M. KRAUTH Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1924, to March 31, 1924.

that I last saw him alive on March 31, 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum, following marasmus, due to artificial feeding after mother died.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Premature at 8 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D. B. Bronnum, M. D.

4-1. 1924 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL April 2 1924

20 UNDERTAKER Lilly and Zeile

ADDRESS 1031 N. Wolfe St

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-2t—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85486

CERTIFICATE OF DEATH.

1 / 29

D 85486

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Ridgely St. Mt Winans 25 St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Richard Robinson

(a) Residence No. Ridgely N Mt Winans St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	Colld	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Robinson

6-DATE OF BIRTH (month, day and year) 1869

7-AGE.	If LESS than 1 day.
53 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer 045

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)?.....
(State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Virginia

14- (Informant) John Robinson

(Address) Ridgely St. Mt Winans

15-

Filed ..... 19.....

APR 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-30-1924

17- I HEREBY CERTIFY, That I attended deceased from

3-10, 1924 to 3-30, 1924

that I last saw him alive on March 30, 1924

and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) L. B. Hall, M. D.

, 19 (Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 4-2, 1924
Mt Auburn Cem	
20-UNDERTAKER. David Tarbert	ADDRESS 916 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

202 D 85487

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

2-FULL NAME James O'Neill

(a) RESIDENCE NO. 3 N. Amity ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora O'Neill.

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Georgeanna Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Records

15 APR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/24

17 I HEREBY CERTIFY, That I attended deceased from 3/20/24, 19..., to 4/1/24, 19..., that I last saw h alive on 4/1/24, 19..., and that death occurred, on the date stated above, at 6:40 a. m.

The CAUSE OF DEATH* was as follows:

Jaundice caused from cancer.

Acute Tuberculosis Pericarditis (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary), Pleurisy - Tuberculosis Pneumonia (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ? Pericarditis

Did an operation precede death? Yes Date of 3/29/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	4-5 1924
20 UNDERTAKER David Easter	ADDRESS 916 Pearl

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85488

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 927 N. Eutaw St. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Estelle Handy

(a) Residence No. 927 N. Eutaw St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Col	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Feb 31 1918~~

6-DATE OF BIRTH (month, day and year) ~~March 31 1924~~

7-AGE.	If LESS than 1 day,
6 yrs. 2 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none old

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Baltimore Md
(State or Country),

PARENTS

10-NAME OF FATHER, Thomas Handy

11-BIRTHPLACE OF FATHER (city or town)..Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Hattie Halliday

13-BIRTHPLACE OF MOTHER (city or town)..Md
(State or Country),

14-(Informant) Hattie Hamilton

(Address) 927 N. Eutaw St.

15-APR 2 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 31-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 4....., 1924 to Mar 31....., 1924 that I last saw her alive on Mar 31....., 1924 and that death occurred, on the date stated above, at 11.55 p.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. 27 mos. days.

CONTRIBUTORY (Secondary) none

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) H. C. Petterson M. D.

, 19 (Address) 817 Hamilton Ter.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
MtAuburn	4-2-, 1924
20-UNDERTAKER.	ADDRESS
Dent Parker	916 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85489

D 85489

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1827 Eagle. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret T. Sigwarth

(a) RESIDENCE. No. 1827 Eagle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ✓ mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Theodore Sigwarth

6 DATE OF BIRTH (month, day, and year) Mch 16-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41	41	✓	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailoress

(b) General nature of industry, business, or establishment in which employed (or employer) Finishing Pants,

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

11 Informant Theresa Knight (Address) 2024 Eagle St.

Filed APR 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923, to Mch 30, 1924, that I last saw her alive on Mch 30, 1924, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows: Valvular Heart Disease

CONTRIBUTORY (Secondary) None (duration) Over 3 mos. 13 ds.

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis? Henry C. Fale, M. D.

(Signed)

1924 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: April 3 1924

20 UNDERTAKER: George J. Smith — ADDRESS: 53 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85490

CERTIFICATE OF DEATH.

131 ✓ D 85490

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma Letton

(a) RESIDENCE NO. 1710 W. Harlem ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Christian Letton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elsie Hartog

13 BIRTHPLACE OF MOTHER (city or town) Columbia
(State or country) Canada

14 Informant Christian Letton
(Address) 1710 Harlem av

15 Dated APR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1924, to April 1, 1924, that I last saw h alive on April 1, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) ..... yrs. ..... mos 18 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Otitis Media

(duration) ..... yrs. ..... mos. (?) ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical & Lab.

(Signed) Isidore L. Fox, M. D.

Apr. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cem

DATE OF BURIAL: Apr 2 1924

20 UNDERTAKER: Jos Jacobs & Son

ADDRESS: 2173 Pen

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

85491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 D 85491

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ader

(a) RESIDENCE No. 231 President ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Ader -

6 DATE OF BIRTH (month, day, and year) May 23, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany -

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Jos. Ader. 231 President St

15 APR 2 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31- 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-24- , 1924, to 3-31- , 1924, that I last saw h[illegible] alive on 3-31- , 1924 and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis
Mitral Insufficiency

(duration) 7 yrs. mos [illegible] ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. D. Parr, M. D.

3/31, 1924 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL April 3 1924

20 UNDERTAKER Geo M. Trail & Son

ADDRESS 811 W Lafayette

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85492

D 85492

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5218 Clant ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sheen

(a) RESIDENCE NO. 5218 Clarent ST., [illegible] WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 1/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Sheen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Helen Fallon

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Jas Lehorer
(Address) 5218 Clarent St.

15 Filed APR 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1/24 19

17

I HEREBY CERTIFY, That I attended deceased from Apr 1/24, 19 ... to Apr 1/24 19 ...

that I last saw he alive on Apr 1/24, 19 ...

and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Diffused Tuberculosis
Peritonitis & Delirium

1 hr
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Diffused Tuberculosis

1 hr
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos B Kelly M. D.

Apr 2/24, 19 (Address) 1202 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL 4/2 1924

20 UNDERTAKER J. J. Lakey & Sons

ADDRESS 318 Eutaw St.

WARNING—REGISTERED UNDER THE LAWS OF MARYLAND

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85493 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85493

CERTIFICATE OF DEATH. 25 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 S 6 at St., 25 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances E Langford

(a) Residence No. 118 S 6 at St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Earl Langford

6-DATE OF BIRTH (month, day and year) July 13 1882

7-AGE. 41 yrs. 8 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Brooklyn Anne Arundel Co Md

PARENTS.

10-NAME OF FATHER, George A Potee

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Mary Hartman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mrs Mary Potee

(Address) 114 E 41st st Brooklyn Md

15-

Filed..... 192.. ROBERT R. KRAUTER, Registrar.

APR 2 1925 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 1 1924

17- I HEREBY CERTIFY, That I attended deceased from March 24 1924 to April 1 1924

that I last saw him alive on April 1 1925

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Chas F Brook M. D.

April 1 1925 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill	April 4 1925
20-UNDERTAKER.	ADDRESS
John F Denny	715 E Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85494

D 85494

CERTIFICATE OF DEATH.

24 24-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 110 E Cross St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice A Sank

(a) Residence No. 110 E Cross St., Ward 24
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of none

6-DATE OF BIRTH (month, day and year) April 9 1871

7-AGE. 52 yrs. 11 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER David N Sank

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Fielding

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) George A Sank
(Address) 110 E Cross st

15-
Filed APR 2 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 31 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922 to March 31, 1924
that I last saw her alive on March 31, 1924
and that death occurred, on the date stated above, at 8 40 p. m.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H Hammond Cook M. D.
April 2, 1924 (Address) 1701 Warren a

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	April 3. 1924
20-UNDERTAKER. John F Denny	ADDRESS. 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85495

CERTIFICATE OF DEATH.

3/ D 85495

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Jasper ST., 17 WARD)

2-FULL NAME Mary Jackson

(a) RESIDENCE NO. 632 Jasper St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Various

9 BIRTHPLACE (city or town) (State or country) Essex Co Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant John Thomas

(Address) 632 Jasper

15 Filed APR 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1924

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1924, to March 31, 1924, that I last saw h[illegible] alive on March 30, 1924, and that death occurred, on the date stated above, at 1230A m.

The CAUSE OF DEATH*, was as follows:

Intracranial Hemorrhage

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 1 mos 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gustav Eckhman, M. D.

, 19 (Address) 606 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: April 2 1924

20 UNDERTAKER: Samuel T Hemsley. 578

ADDRESS: W. Biddle S

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85496

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-002

D 85496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 936 Headenhall St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah J Palmer

(a) Residence No. 936 Headenhall St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm C Palmer

6-DATE OF BIRTH (month, day and year) June 9 1883

7-AGE. 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER Aaron Thomas.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Wm. C. Palmer.

(Address) 936 Headenhall St.

15- APR 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3/30/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 7, 1924 to Mch 30, 1924 that I last saw h.. alive on Mch 29, 1924 and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

3/31, 1924 (Signed) H S McCaul M. D.

(Address) 1005 Hillsdale Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Auburn Cem.	April 2, 24
20-UNDERTAKER.	ADDRESS
Samuel T. Hemsley.	578 W Biddle St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 ✓ D 85497

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aron David Kriegen

(a) RESIDENCE NO. 3404 Morris Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Kriegen

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
5-6			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Jack Kreegen

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Adler

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

Filed APR 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Antecedent conditions)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Apr 1, 192 4 (Coroner) (Address) 1639 Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In this State 4 yrs. mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Rd — DATE OF BURIAL 4/2 192 4

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

John S. Barnes.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85498

D 85498

CERTIFICATE OF DEATH.

65-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital, ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S. Barnes.

(a) RESIDENCE No. 911 E. Federal St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Barnes.

6 DATE OF BIRTH (month, day, and year): Mar 18th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ship Builder

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: George Barnes.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susie Graves.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John F. Barnes. (Address): 1232 Asquith St

15 Filed APR 2 - 1924 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 31 1924

I HEREBY CERTIFY, That I attended deceased from March 26 1924 to March 31 1924

that I last saw him alive on March 31 1924

and that death occurred, on the date stated above, at 10-18 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Blood, Ecka.

What test confirmed diagnosis?

(Signed) J. C. Schramm, M. D.

19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	April 5 1924
20 UNDERTAKER	ADDRESS
Leo G. Cook	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85499 ✓ D 85499

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1335 Madison ST.: 13 WARD)

2-FULL NAME Mrs Rebecca Goodman

(a) RESIDENCE. NO. #1335 Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dawid Goodman (Deceased)

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Berton Hlavsky

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country) —

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Bessie Goodman

(Address) 2735 Madison Ave

15 Filed ....., 19 .... ROBERT R. KRAMER Registrar

APR 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to April 2nd, 1924, that I last saw her alive on April 1st, 1924, and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis; Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Strauss, M. D.

, 19 (Address) 360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holbrew Southern Ave.	April 2 1924
20 UNDERTAKER S. Levinson Bro.	ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85500

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85500

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 Park Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Millard Boardman

(a) Residence No. 1701 Park Ave St., 14 Ward Helena Montana

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. ? ds. How long in U. S., if of foreign birth? 69 yrs. 3 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Boardman

6-DATE OF BIRTH (month, day and year) Dec-2-1854

7-AGE, 69 yrs. 3 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dealer in Live Stock.

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) Dixon (State or Country), Illinois

PARENTS.

10-NAME OF FATHER, Thadias D. Boardman

11-BIRTHPLACE OF FATHER (city or town) Newyork (State or Country), Newyork

12-MAIDEN NAME OF MOTHER, Mary Richards

13-BIRTHPLACE OF MOTHER (city or town) Dixon (State or Country), Illinois

14- (Informant) Mrs Anna Boardman (wife)

(Address) Helena - Montana

15- Filed APR 2 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr-1-1924.

17- I HEREBY CERTIFY, That I attended deceased from Dec 17, 1923, to April 1, 1924, that I last saw him alive on April 1, 1924, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(Duration) 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Electrocardiogram.

(Signed) Henry M. Thomas Jr., M. D.

, 19 (Address) 122 S Madison Ave - Helena

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Helena Montana — DATE OF BURIAL, Apr 2, 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS In plain terms, so that it may be properly classified. Exact statement of OCCU instructions on back of certificates.

TC DATA AN I LY S AND HEA NES TH

Spec.—1-10-21—M&T—1500 Bks.

(Smith)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85501

D 85501

CERTIFICATE OF DEATH.

+76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1938 White ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Malvina Smith

(a) RESIDENCE NO. 1938 White ST., WARD Annapolis Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Perry L. Smith

6 DATE OF BIRTH (month, day, and year) March 25, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Homestead

(c) Name of employer American Legion Auxiliary

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rebecca Kirby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant (Address) Mrs. Emma M. Gross 1938 White St.

15 Date APR 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1924

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1924, to April 1, 1924, that I last saw her alive on March 31, 1924, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) 0 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1/2 mos. 1 ds.

18 Where was disease contracted if not at place of death? Annapolis

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Signs

(Signed) Walter [illegible], M. D.

4-2 1924 (Address) 166 W Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bruer Hill A.M.E. Co

DATE OF BURIAL Apr 2, 1924

20 UNDERTAKER Sam'l H. Chase & Son

ADDRESS 1400 N Gilmor

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85502

D 85502

CERTIFICATE OF DEATH.

Registered No. 89

1-PLACE OF DEATH 512 N Rose St

City of BALTIMORE: (No. 512 N. Rose St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Parker

(a) Residence No. 502 N. Rose St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND ~~of or~~ WIFE of Alice E Parker

6-DATE OF BIRTH (month, day and year) Feb 22 - 1877

7-AGE, 47 yrs. One mos. None ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William Parker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Elizabeth Gray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Alice E. Parker

(Address) 502 N. Rose St

15- Filed APR 2 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 31, 1924

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1924, to Mar. 31, 1924, that I last saw him alive on Mar. 31, 1924, and that death occurred, on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) yrs. mos. Mo ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 3 (?) mos. ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Manual test

(Signed) C. C. Macdonald, M. D.

April 1, 1924 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: April 3, 1924

20-UNDERTAKER: Robt G Gurney & Son — ADDRESS: 1425 N. Broadway

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85503

CERTIFICATE OF DEATH.

D 85503

REGISTERED NO. 100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Hull ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Francis Reidy

(a) RESIDENCE. NO. 1208 Hull ST., 24 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 17, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none (Baby)

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Donald Franklin Reidy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wash D.C.

14 Informant: Mrs Reidy
(Address): 1208 Hull St

13 Filed APR 2 - 1924 19 Robert P. [illegible] Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31st, 1924, to April 2, 1924, that I last saw h[illegible] alive on April 1, 1924, and that death occurred, on the date stated above, at 3:06 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) George C. Mulcahy, M. D.

, 19 (Address) 3304 Gilman Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	April 2 1924
20 UNDERTAKER	ADDRESS
A. Howard Evans	38 E Ford Ave

MARGIN RESERVED FOR REGISTRAR'S USE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85504

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 W 28th St St. 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Richard T Snouffer

(a) Residence No.. 312 W. 28th St St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married ~~Widowed~~, ~~or Divorced~~, (Write the word.) married

5a-If married, widowed or divorced HUSBAND of (or) WIFE of Caroline E Snouffer

6-DATE OF BIRTH (month, day and year) Jan 25 1849

7-AGE, 75 yrs. 2 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Joshua Snouffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14-INFORMANT (Name). Wm W Snouffer

(Address) 312 W 28 St

15-DATE RECEIVED. APR 2 - 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 1924

17-I HEREBY CERTIFY, That I attended deceased from Oct 1 23, to April 1, 24, that I last saw h. alive on April 1, 24, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) Few days yrs. mos. ds.

CONTRIBUTORY Carcinoma ?
(Secondary)

Liver (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E A Richardson M.D.

April 1924 (Address) 1120 W 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Hampden

DATE OF BURIAL, April 4 1924

20-UNDERTAKER. CHENOWETH & SON

ADDRESS 217 CHESTNUT AVE.

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85505

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 W 37th St Ward 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Morrison

(a) Residence No. 1111 W 37th St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 5 1898

7-AGE, 26 yrs. 11 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Hugh L Morrison

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Rose Hamond

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Raymond Hunt

(Address) 1111 W 37th St

15- Robert P. Harris

Registrar.

APR 2 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Mch, 1924, to April 2, 1924,

that I last saw h. alive on March 30, 1924,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1111 W 37 St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm Gilman Thomas, M. D.

of —, 1924 (Address) 330 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn DATE OF BURIAL, April 4, 1924

20-UNDERTAKER CHENOWETH & SON ADDRESS 317 CHESTNUT AVE

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85506 ✓ D 85506

CERTIFICATE OF DEATH.

193

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 E Eager St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lewis Ripperger

(a) Residence No..... 710 E. Eager St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Dec 17-1864

7-AGE, 59 yrs. 3 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Matress Maker 31

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Anthony Ripperger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Mary Ziegler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Katherine Kennedy

(Address): 710 E. Eager St.

15-

APR 2 - 1924

16-Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3/31/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 6, 1923, to 3/31, 1924,

that I last saw h.. alive on 3/31, 1924,

and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Papilloma - adenoma of bladder

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Pyelitis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr Bernard Wess, M. D.

4/2, 1924 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer DATE OF BURIAL: April 3 1924

20-UNDERTAKER: H. C. Wiedefeld ADDRESS: 914 Fremont Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85507

CERTIFICATE OF DEATH.

7/1-001

D 85507

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Ernestine Copsey

(a) RESIDENCE NO. 50 E. 26th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James E Copsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Bertha Slaughter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant James E Copsey

(Address) 50 E. 26th St

15 Filed APR 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1924

17

I HEREBY CERTIFY, That I attended deceased from March 27th, 1924, to March 31st, 1924, that I last saw her alive on March 31st, 1924, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

1

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. findings & Lab. findings

(Signed) James Durkin, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Apr 3 1924

20 UNDERTAKER J. F. Lenhardt Sons

ADDRESS N & Pa

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 85508

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2517 Maryland Av Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Albina F. Stehlgauten

(a) Residence No. 2517 Maryland Av St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widow

5a-If ~~married~~, widowed, or ~~divorced~~, ~~HUSBAND~~ of (or) WIFE of Charles Stehlgauten

6-DATE OF BIRTH (month, day and year) May 26 1845

7-AGE, 78 yrs. 10 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Vogell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louisa Kesmodel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Lillie F. Stehlgauten

(Address) 2517 Maryland Av

15-

Filed APR 2 - 1924 Robert P. Harris Registrar.

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). APR 1 - 1924

17- I HEREBY CERTIFY, That I attended deceased from February 25, 1924, to April 1, 1924, that I last saw h[illegible] alive on April 1, 1924, and that death occurred, on the date stated above, at 6.45 p.m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(Aortic regurgitation)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. M. Stevenson M. D.

APR 2 - 1924 (Address) 2733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine

DATE OF BURIAL, APR 4 - 1924 ....., 19....

20-UNDERTAKER. Geo W Little

ADDRESS 2760 EDMONDSON AVE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85509

CERTIFICATE OF DEATH.

44 D 85509

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 E Lombard ST., 2 WARD)

2-FULL NAME Caroline Pscherer

(a) RESIDENCE No. 2029 E Lombard ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emeran Pscherer

6 DATE OF BIRTH (month, day, and year) Aug 6 1864.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
60	60.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER Henry Grebe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Cattman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emeran Pscherer
(Address) 2029 E Lombard

15 Filed APR 2 -1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/15 1924 to 3/31 1924

that I last saw her alive on 3/31 1924

and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Colder M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 3 1924

20 UNDERTAKER Wendell Ruppel's Son — ADDRESS 878 Linn

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85510 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85510

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Buren Stanley

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Ferrum. Franklin Co - Va

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? 22 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer ~~Silk worker~~

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ferrum, Franklin Co. Va

PARENTS

10 NAME OF FATHER W. L. Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ferrum Va

12 MAIDEN NAME OF MOTHER Cora R. Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 1924, to April 2, 1924, that I last saw him alive on April 2, 1924, and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor — malignant glioma — Right frontal

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Mar 28 24

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) F. R. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roanoke Va — DATE OF BURIAL 4/3/24

20 UNDERTAKER Joseph Akers — ADDRESS 221 Bway

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85511

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 N. Appleton ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Lee Lettau

(a) RESIDENCE. NO. 919 N. Appleton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 4 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER August F. Lettau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Schempf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville Maryland

14 Informant August F. Lettau

(Address) Maryland 919 N Appleton

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 30 . 1924 . to April 2 . 1924.

that I last saw him alive on April 2 . 1924.

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) Dorus A. Baggott M. D.

. 19 (Address) 1015 Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/3/24
20 UNDERTAKER	ADDRESS
Geo. Weber, Son	2503 Edmondson Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85512

CERTIFICATE OF DEATH.

-118-002

D 85512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Edward Butler

(a) RESIDENCE NO. 1833 Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year) May 10 1907

7 AGE: Years 16; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Mary's Co

PARENTS

10 NAME OF FATHER: John E Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Julia Moss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): John E Butler 1833 Lanvale St

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/26, 1924, to 3/30, 1924

that I last saw him alive on 3/30, 1924,

and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) J. Norwood Wilson M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 3 1924

20 UNDERTAKER: Mark R. G. Elliott ADDRESS: 2 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85513

CERTIFICATE OF DEATH.

129 D 85513

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: NO. 1720 Druid Hill Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Brown

(a) RESIDENCE. NO. 1720 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Widowers

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Ellen Ridgely Brown

6 DATE OF BIRTH (month, day, and year) Aug 7, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Nicholas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Marguerite Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Winchester Frederick Co. Va

14 Informant Henry Brown (Address) 1720 Druid Hill Ave

15 Filed ... 19 ... ROBERT R. KRAUTER, Registrar

APR 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1924

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to March 31, 1924, that I last saw h alive on March 30, 1924, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Varicose Ulcers (duration) 2 yrs, mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Physical

(Signed) Wilbur H Wright, M. D.

April, 1924 (Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. AuBurn Cem.	4/3/24 19

20 UNDERTAKER Samuel Wensley Wheeler ADDRESS 538

Spec.—8-24-14—M. & T.—2000 Bks.

D 85514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85514

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Argyle Av St. 14 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Cecelia Thomas

(Residence in Baltimore: No. 1430 Argyle Av St.: ....yrs.. ....mos. 13 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, Mar. 20, 1924. (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Richard Thomas

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co.

12-MAIDEN NAME OF MOTHER Anna Cassell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Anna Cassell

(Address) 1430 Argyle Ave

15- APR 3 1924 ROBERT R. KRAUTER, Registrar.
Filed....., 191.... Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April — 1 —, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch. 30. 1924, to Apr. 1 1924, that I saw her alive on Apr 1 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cause — Colitis

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

Apr 2, 1924 (Address) 1423 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem.	3/3/....., 1924
20-UNDERTAKER Samuel A Hemsley	ADDRESS 578 W Biddle

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85515

Spec.—1-10-21—M&T—1500 Bks.

D 85515 HEALTH DEPARTMENT—CITY OF BALTIMORE

135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Porden Stewart

(a) RESIDENCE NO. 15-25 Angola Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845-8

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hospital Record

(Address)

15 APR 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/24 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/24, 19..., to 4/1/24, 19...

that I last saw h~~e~~ alive on 4/1/24, 19...

and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Prostatic Hypertrophy

(Benign)

.....(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes. Date of 3/25/24

Was there an autopsy? No

What test confirmed diagnosis Clinical Course

(Signed) K. W. Hosley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Mt. AuBurn Cem.	4/3/24 19
20 UNDERTAKER Samuel Hawley	ADDRESS 32 W Saratoga St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Adley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85516

CERTIFICATE OF DEATH.

74001

D 85516

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 George St. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Adley

(a) RESIDENCE NO. 612 George St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Esther Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Georgeanna Allen (Address) 612 George St.

15 APR 3 - 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 24

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to March 31 1924, that I last saw h[illegible] alive on March 3 1924, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemiplegia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles B. Fowler, M. D.

4/6, 1924 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. AuBurn Cem.	4/2/24

20 UNDERTAKER Samuel D. Handley ADDRESS Madison

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16a 593 85517

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., WARD)

2-FULL NAME Michael Miller

(a) RESIDENCE NO. Prospect Park ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 mos. 23 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Annie Hlopaka

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Andrew —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Gaibreth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 3 -1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1924, to Mar 31, 1924, that I last saw him alive on Mar 31, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pott's Disease (Lower Thoracic Vertebrae).

Aneurysm (Descending Arch of Aorta).

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pleural Effusion - Bilateral - Tuberculous

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Autopsy, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL April 4 1924

20 UNDERTAKER Frank Erachton

ADDRESS 1906 Gorkland

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-98 85518

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 N. East Ave ..... St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME NELLIE SKURMAN (Petronele Scadmon)

(a) Residence No. 409 N. East Ave ..... St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 days — mos. — ds. How long in U. S., if of foreign birth? 10 yrs. mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) 1861

7-AGE. About 63 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... No

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Lithvahia

PARENTS.

10-NAME OF FATHER, Nknow

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lithania

12-MAIDEN NAME OF MOTHER, No

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lithvania

14- (Informant) Victoria Maccis

(Address) 409 N. East Ave

15- Filed 192

ROBERT R. KRAUTER, Registrar.

APR 3 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 1. 1924

17- I HEREBY CERTIFY, That I attended deceased from ..31. March ..... 1924 ..to..31. March 1924

that I last saw h.e. alive on ..31. March 1924

and that death occurred, on the date stated above, at 1. P. ....m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph A. Bonnaventure M. D.

, 19 (Address) 604 S. Paca St. Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer

DATE OF BURIAL, April 4th 1924

20-UNDERTAKER, John Grebliauckas

ADDRESS 425 S Paca St.

F.D.

should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85519

CERTIFICATE OF DEATH.

D 85519

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1606 N. Vincent St. 15 WARD)

2-FULL NAME Joseph Mabey

(a) RESIDENCE NO. 1606 N. Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) odd
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Florence Johnson
(Address) 923 Vincent Ave

15 Filed APR 3 - 1924 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

April 3, 1924 (Address) 200 Courtland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL April 4, 1924

20 UNDERTAKER Jessee Redden

ADDRESS 432 Bentalou St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN FOR BINDING

MARGIN RÉSERVÉE POUR LA RELIURE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85520

CERTIFICATE OF DEATH.

D 85520

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Mullen St ST., 15 WARD)

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 1814 Mullen St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15, 19[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.,
(State or country)

PARENTS

10 NAME OF FATHER Jos. Smith

11 BIRTHPLACE OF FATHER (city or town) Md.,
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md.,
(State or country)

14 Informant Jos. Smith
(Address) 1814 Mullen St

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

gastro-enteritis

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

(Address) 250 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL April 3 1924

20 UNDERTAKER Jesse Redden

ADDRESS 432 Biddle St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85521

CERTIFICATE OF DEATH.

X 100-001 D 85521

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1104 S Sharp ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) W. 6.

2-FULL NAME Moses Hand

(a) RESIDENCE NO. 1104 S Sharp ST., 23 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Hand
(Address) 1104 S Sharp St

15 APR 3 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/24

17 I HEREBY CERTIFY, That I attended deceased from 3/30/24, 19..... to 4/1/24, 19 24.

that I last saw h alive on 4/1/24, 19 24;

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Morasmus + Bronchitis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Rena Worley, M. D.

4/2, 19 24 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL April 3 1924

20 UNDERTAKER S. L. Brown & Son

ADDRESS 1010 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very imprtant. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85522 (Wasilessky) ✓

(7037)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 25 ..... WARD)

2-FULL NAME Michael Wasilensky

(a) RESIDENCE No. 1423 Curtis Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. ~~2~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Steve —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant ..... (Address) JOHNS HOPKINS HO

15 APR 3 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 3 , 1924 to Mar 31 , 1924 ,

that I last saw him alive on Mar 31 , 1924 ,

and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Inflammation Chronic Nephritis Secondary Anemia

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) — Intestinal Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. R. Harmon, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.A. Co.	April 4 1924
20 UNDERTAKER	ADDRESS
John B. Weber	1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85523

CERTIFICATE OF DEATH.

5 7 D 85523

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Sophia Ashman

(a) RESIDENCE NO. 2226 E. Madison ST., [illegible] WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Ashman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Rosengarten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Ashman
(Address) 2226 E. Madison St.

15 Filed APR 3 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitis (duration) 10 yrs. mos. ds.

(Signed) J. S. H. Vallin, M. D.
(Coroner.)

April 2nd 1924 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/3 192 4

20 UNDERTAKER Joel Lewis ADDRESS 1434 E Baltimore

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85524

CERTIFICATE OF DEATH.

D 85524

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2446 Woodbrook Ave St., 43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Solomon Rosenbloom

(a) Residence No. 2446 Woodbrook Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Rosenbloom

6-DATE OF BIRTH (month, day and year) 8/1/1871

7-AGE. 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14-Informant) Jack Laurs

(Address) 1439 E Balto St

15-Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 1. 1924

17- I HEREBY CERTIFY, That I attended deceased from October, 19.23. to April 1, 19.24.

that I last saw him alive on April 1st 19.24.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Hollander M. D.

, 19 (Address) 1810 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Southern Ave — DATE OF BURIAL, 4-7, 19.24

20-UNDERTAKER, Jack Laurs 1439 — ADDRESS E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 D 85525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Retreat

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

2-FULL NAME Emma Webster

(a) RESIDENCE NO. Mount Hope Retreat ST. 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) (?)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	42	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md.

15 Filed APR 3 - 1924 19 Registrar

ROBERT A. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Apl 13- 1896 to Apr 2 1924,

that I last saw her alive on Apr 2, 1924, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr Uterine Fibroseptic Tumor

abt (duration) 10 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Chr Melancholia

abt (duration) 28 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington DC

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Filamery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Apr 5 1924
20 UNDERTAKER STUART & MOWEN COMPANY, WILLIAM F. WOODEN, Successor	ADDRESS 108 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85526

CERTIFICATE OF DEATH.

D 85526

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. George Pfeiffer

(a) RESIDENCE NO. 604 N. Chester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown Mar 9/61

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Conrad Pfeiffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Harry A. Pfeiffer
(Address) 3827 Wilkins Ave

15 Filed APR 3 - 1924 [illegible] KRAUTH, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs & Meninges
(Large retro-peritoneal tumor, probably malignant. Autopsy at Hopkins Hospital (Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Fallen, M. D.
(Coroner.)

Apr. 6/24 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Apr. 3 1924

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85527

D 85527

CERTIFICATE OF DEATH.

11-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1027 N. Milton Ave. St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton F. Thompson

(a) Residence No. 1027 N. Milton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 10 23

7-AGE. ..... yrs. 7 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER, Milton F. Thompson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Ella V. Wemuth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

11- (Informant) Milton F. Thompson

(Address) 1027 N. Milton Ave

15- Filed APR 3 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/2/24

17- I HEREBY CERTIFY, That I attended deceased from 3—31—24 to 4—2—24

that I last saw h.. alive on 4—2—24

and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. F. Rellahan M. D.

(Address) 1000 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Pk

DATE OF BURIAL. 4/4/24

20-UNDERTAKER. Philip Herrig

ADDRESS 2016 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No.....St., 24 31 ....Ward) Municipal Tuberculosis Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Arndt

(a) Residence No. 1204 Towson st. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Singl

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885

7-AGE.	If LESS than 1 day,
39 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Herman Arndt

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Hospital Records

(Address) M.T.H.

15- FILED APR 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 31, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 26 1924 to March 31 1924

that I last saw him alive on March 31 1924

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally, M. D.

3-31-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill	4/3 1924
20-UNDERTAKER	ADDRESS
J. J. Lafayette	318 Light St.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85529 **CERTIFICATE OF DEATH.** 100-00D 85529

1-PLACE OF DEATH CITY OF BALTIMORE: (No. St. Elizabeths' Home Chemnt Hgts Ave ST.; 9 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Armentha Peresa Griffin

(Residence in Baltimore: No. St. Elizabeths' Home St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	negress	

6-DATE OF BIRTH, April 27, 1923
(Month) (Day) (Year)

7-AGE, 1 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Levi Driver

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Pumacher Griffin

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed APR 3 - 1924 ROBERT P. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 29, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from February 1 1924, to March 29 1924, that I saw h-- alive on March 29 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration)....yrs....mos. 3 ds.

(Signed) Frank J. Ayd M. D.

March 30, 1924 (Address) 2005 E Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

20-UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health
APR 2-1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85530 CERTIFICATE OF DEATH.

161-001 D 85530

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Belt ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Newton Myrick

(a) RESIDENCE NO. 1411 Belt ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 30 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Newton Myrick

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Millard

13 BIRTHPLACE OF MOTHER (city or town) Del
(State or country)

14 Informant Mrs R. Myrick
(Address) 1411 Belt St.

APR 3 - 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

105

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 30, 1924, to Mar 31, 1924,

that I last saw him alive on Mar 31, 1924,

and that death occurred, on the date stated above, at 12-30 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 Months Gestation

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. F. Campbell M. D.

Mar 31, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Rohrer State Board

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

APR 2

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85531

D 85531 CERTIFICATE OF DEATH. 100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST. 76 WARD)

2-FULL NAME James Myers

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED:

(a) Trade, profession or particular kind of work Laborer 940

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 192x

17 I HEREBY CERTIFY, That I attended deceased from 11-29, 1923 to 3-31, 192x that I last saw him alive on 3-30, 192x and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude E. Drane, M. D.

4-1, 192x (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL 19

20 UNDERTAKER Health. ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85532

CERTIFICATE OF DEATH.

161-001 ✓

D 85532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillsdale ST., 26 WARD)

2-FULL NAME Infant of Mr & Mrs Charles Cooper

(a) RESIDENCE No. Hillsdale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 28/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles N. Cooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Ida E. Cooper

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Charles N. Cooper
(Address) Hillsdale ave

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1924, to April 2, 1924,

that I last saw h~~e~~ive on April 1, 1924

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

Signed Chas R. Campbell, M. D.

April 2, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 3 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85533

179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 843 Woodward St., 71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Rollins

(a) Residence No. 843 Woodward St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) ~~WIFE~~ of Elizabeth Rollins

6-DATE OF BIRTH (month, day and year) May 18 1852

7-AGE. 71 yrs. 10 mos. 15 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer). Labor 040

(c) Name of employer. B. & O. R. R.

9-BIRTHPLACE (city or town) (State or Country). Iowa

PARENTS.

10-NAME OF FATHER. Perry Rollins

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Nancy Prentice

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14-(Informant). Elizabeth Rollins

(Address) 843 Woodward St

15-Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to April 2 1924

that I last saw him alive on April 2 1924

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Morley Strong M. D.

1423. 1924 (Address) 729 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL. April 4 1924

20-UNDERTAKER. Jos Sorsdeni Jr

ADDRESS 2173 Oswego

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85534

CERTIFICATE OF DEATH.

167-001 D 85534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST., Hospital WARD) 22

2-FULL NAME Frank Enson. (C).

(a) RESIDENCE NO 100 Key Highway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer, Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Police Report (Address) UNIVERSITY OF MARYLAND

15 Filed APR 3 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry & autopsy. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Poisoning.
Suicide.
Lobar Pneumonia.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto Reinhardt, M. D. (Coroner.)

March 31, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL APR 5 1924 192

20 UNDERTAKER ADDRESS

Dept. Director of Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85535

CERTIFICATE OF DEATH.

X 167-09 D 85535 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Hunt.

(a) RESIDENCE NO 1714 N. Charles ST., St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) December 15. 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodbury N.J.

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Police Report (Address)

15 Filed APR 3 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk
THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphyxia.
Suicide.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

March 8th, 192 4 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND APR 3 - 1924

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85536

CERTIFICATE OF DEATH.

8122-08 D 85536

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2736 Belair Road ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Oliver Arrington

(a) RESIDENCE. No. 2736 Belair Road ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

(a) If married, widowed or divorced HUSBAND of (or) WIFE of Mary V. Arrington

6 DATE OF BIRTH (month, day, and year) Nov 28 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57.	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER Austin Arrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known.

14 Informant Mary V. Arrington
(Address) 2736 Belair Road

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1923, to Apr. 1, 1924, that I last saw him alive on Apr. 1, 1924 and that death occurred, on the date stated above, at 8.20 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(duration) yrs. mos. dy.

18 Where was disease contracted if not at place of death? Organic

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Alex Lemmey, M. D.

19 (Address) Catonsville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield Cem. Lockwood	April 4 1924
20 UNDERTAKER	ADDRESS
E. A. Weidefeld Jr	501 E 22 St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85537

CERTIFICATE OF DEATH.

31 D 85537

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 N. Gay Street ST.: 8 WARD)

2-FULL NAME John T. Childs

(a) RESIDENCE. No. 1418 N. Gay Street ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie B. Childs

6 DATE OF BIRTH (month, day, and year) Jan. 19, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George T. Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Bessie B. Childs.
(Address): 1418 N. Gay Street.

15 APR 3 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 1 - 1924

17 I HEREBY CERTIFY, That I attended deceased from FEB 26 1924, to APR 1 - 1924.

that I last saw him alive on APR 1 - 1924.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from lungs

(duration) X yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) X yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? not Known

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. H. Decker, M. D.

APR 2 - 1924, 19 (Address) 928. E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	4/5/ 19 24

20 UNDERTAKER: Albert L. Hiltz Jr 1606 N Chester St

ADDRESS 1606

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85538

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85538

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 S. Garrison Lane ST., 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Zimmerman

(a) RESIDENCE No. 123 S. Garrison Lane WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Zimmerman

6 DATE OF BIRTH (month, day, and year) Dec 31-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md. (State or country)

PARENTS

10 NAME OF FATHER Wm. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna H. Eubel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Zimmerman (Address) 123 S. Garrison Ave

15 Filed APR 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1923, to April 2, 1924, that I last saw h— alive on April 1, 1924 and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) Howard W John M. D.

(Address) 222 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	4/5 1924
20 UNDERTAKER Zickler & Zickler	ADDRESS 1739 Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

Kirk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85539

CERTIFICATE OF DEATH.

90

D 85539 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3411 N Fd. Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elizabeth Atkinson

(a) Residence No. 3411 N Fd Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of David B.

6-DATE OF BIRTH (month, day and year) March 25 1844

7-AGE, 80 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), England

PARENTS.

10-NAME OF FATHER, Robt Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Sarah Kemp

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Mrs Agnes Arnold

(Address) 3411 N Fd Road

15- APR 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1st, 1923, to April 3rd, 1924, that I last saw her alive on April 3rd, 1924, and that death occurred, on the date stated above, at 5.40 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert L. Kirk, M. D.

4/3, 1924 (Address) 3126 Hartford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Edgewood DATE OF BURIAL, April 5, 1924

20-UNDERTAKER, H. M. Cook ADDRESS 902 E. Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85540

CERTIFICATE OF DEATH.

D 85540

1-PLACE OF DEATH

City of BALTIMORE: (No. 5222 Wilkens Ave 27 Ward) 101

Registered No. 001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mamie B Gardner

(a) Residence No. 5222 Wilkens Ave ....St., ... Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Gardner

6-DATE OF BIRTH (month, day and year) Dec 24/1868

7-AGE, ...55.... yrs. ....4.... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... at Home
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Co

PARENTS.

10-NAME OF FATHER, John H Craig

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Margaret A Black

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) George Gardner
(Address) 5222 Wilkens Ave

15- Filed APR 3 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 24/24

17- I HEREBY CERTIFY, That I attended deceased from March 24, 1924 to April 2, 1924, that I last saw h.. alive on April 2, 1924 and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 2 4 ds.

CONTRIBUTORY (Secondary) Thrombosis Toxaemia

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. N. Bishop, M. D.

April 3, 1924 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount DATE OF BURIAL, April 5, 1924

20-UNDERTAKER, Williams Carlson & Nathan ADDRESS

MARGIN RESERVED FOR BINDING.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85541

CERTIFICATE OF DEATH.

5 D 85541

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 470 r Eastern Ave St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A - MacFarlane

(a) Residence No. 470 r Eastern Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A MacFarlane

6-DATE OF BIRTH (month, day and year) 12/29/1870

7-AGE, 53 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm G. Hobbs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Casby

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-INFORMANT, J Howard MacFarlane

(Address) 470 r Eastern

APR 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 2/24

17-I HEREBY CERTIFY, That I attended deceased from March 30, 19 24 to April 2, 19 24

that I last saw her alive on April 2, 19 24

and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Following test for Sugar

(Signed) Caleb N Athey, M. D.

April 2, 1924 (Address) 100 S Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oakland	April 5, 19 24
20-UNDERTAKER. Wm Cook	ADDRESS 502 E North Ave

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Kachmarcek)

D 85542

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 85542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hopitel ST., 2 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kachmarick

(a) RESIDENCE No. 1602 Aliceanna ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital
(Address)

15 APR 3 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 1923, to 4-2, 1924 that I last saw her alive on 4-2, 1924 and that death occurred, on the date stated above, at 12-10 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. .. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Hoag, M. D.

4-2 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Bon.	4/4 1924
20 UNDERTAKER	ADDRESS
W. F. Sadowski	705 S. Linn

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 328
D 85543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-801 ✓
100-D 85543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., 18 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Doe

(a) RESIDENCE NO. Florence Crittenden Home WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	-	2	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant
(Address)

15 Filed APR 3 1924 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1924, to Mar 26, 1924, that I last saw h— alive on Mar 26, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florence Crittenden Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. R. Marsh, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL
Commissioner Health.

OFFICE HOURS { 1 TO 2 P. M. / 6 TO 8 P. M.
SUNDAYS BY APPOINTMENT ONLY

WALTER E. KNICKMAN, M. D.
2002 W. LEXINGTON STREET

C. & P. PHONE
GILMOR 2287

BALTIMORE, MD. August--7--- 191 1924.

Recorder of Deaths,
Health Department,
Baltimore, Md.

Dear Sir:-

Would you kindly have correction made in record of death of David F. H. Ohr, 512 N. Arlington Avenue, who died April 11th, 1924.

The said David F. H. Ohr being 81 years, having been born Feb. 27th, 1843.

Have since learned through Mrs. Ohr, that her son made a mistake in age at time of death.

By so doing you will greatly oblige,

Very truly yours,

Walter E Knickman M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85544 ✓

D 085544 24

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST., 6 WARD)

2-FULL NAME Marcellus Davis

(a) RESIDENCE NO. 19 N. Carolene St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 27 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1 (one)	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Marcellus Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, Registrar

APR 3 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924 to March 29, 1924

that I last saw him alive on March 29, 1924.

and that death occurred, on the date stated above, at 6-08 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. B. Wreath, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER — Commissioner Health.

ADDRESS

APR 3 - 1924

MARGIN RESERVED FOR BINDING

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85545

CERTIFICATE OF DEATH.

90D 85545

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 N. Milton ave ST., 8 WARD)

2-FULL NAME Frank. F. Neville.

(a) RESIDENCE NO. 1800 N Milton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Neville

6 DATE OF BIRTH (month, day, and year) Feb 17, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	~~10~~ 1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Magneto Machine Co.

(c) Name of employer Geo Hull & Gordon Parks

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Neville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ella Fleming.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Rebecca Neville
(Address) 1800 N Milton

15 APR 3 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to apr. 2, 1924.

that I last saw h live on apr 2, 1924,

and that death occurred, on the date stated above, at 10 40 p m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) ... yrs. ... mos. 1 hour ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos F. Stevens M. D.

4/3, 1924 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apl 5 1924

20 UNDERTAKER Robt J Turner

ADDRESS 4 Pitt

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85546

CERTIFICATE OF DEATH.

100-00 ✓ D 85546

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis White

(a) Residence No. 1202 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jack J White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) J. J. White

(Address) 1202 E Biddle St

15- Filed APR 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Gork.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/3/24.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1924 to April 3, 1924 that I last saw him alive on April 3, 1924 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Varicose ulcer left leg

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Apl 4 1924
20-UNDERTAKER.	ADDRESS
Robt J Turner Inc	1 N Bway.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85547

CERTIFICATE OF DEATH.

129 D 85547

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Orchard St. St., 17 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Wormley

(a) RESIDENCE NO. 436 Orchard St. St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Wormley

6 DATE OF BIRTH (month, day, and year) about 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hod Carrier
(b) General nature of industry, business, or establishment in which employed (or employer) 035
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Moses Wormley

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Virginia Wormley
(Address) 436 Orchard St.

15 Filed APR 3 - 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. C. T. Hemsley, M. D.
(Coroner.)
April 2, 1924 (Address) 2 E Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 4-4 1924

20 UNDERTAKER Harris Evans 916 Penna Ave — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85548 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85548

CERTIFICATE OF DEATH.

Registered No. 1674

1 PLACE OF DEATH

City of BALTIMORE: (No. 805 Whitecot St., 16 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Chase

(a) Residence No. 805 Whitecot St., Ward

(Usual place of abode) since 1919 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Rose Chase

6-DATE OF BIRTH (month, day and year) Nov-5-1877

7-AGE, 46 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Day labor

(c) Name of employer Ed. Martin

9-BIRTHPLACE (city or town) (State or Country), Howard Co. Md.

PARENTS.

10-NAME OF FATHER, Wm Henry Chase

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Howard Co. Md.

12-MAIDEN NAME OF MOTHER, Mary Howard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Howard Co. Md.

14- (Informant) John Chase (Address) 1231 W. Lafayette ave

15- Filed Apr 3 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 1-'24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 28 1924, to Apr. 1 1924, that I last saw ~~him~~ alive on Mar 31 1924, and that death occurred, on the date stated above, at 9-00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None, apparent from symptoms

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Star Cem — DATE OF BURIAL, 4-4 1924

20-UNDERTAKER, David Easton — ADDRESS 916 Park ave

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85549

D 85549

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Lulu Williams

(a) RESIDENCE NO. 4 S. Caroline St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jim Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Hattie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924, to April 2, 1924, that I last saw her alive on April 2, 1924, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2½ yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary embolism - Instantaneous

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4-5 1924
20 UNDERTAKER	ADDRESS 916 Park
Annie O Taylor	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85550

CERTIFICATE OF DEATH.

1 29 D 85550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 L Wilson ST., 16 WARD)

2-FULL NAME Caroline Thornton

(a) RESIDENCE NO. 1106 L. Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Thornton

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House mnk

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Joseph Thornton

(Address) Middlesex Co. Va.

15 APR 1 1924 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 29, 1924, to Apr 1, 1924, that I last saw her alive on Mar 31, 1924, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs ? mos ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

4/2, 1924 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Banner Wks. Va.	4-4 1924
20 UNDERTAKER David Earhart	ADDRESS 916 Penn Ave

Spec.—6-9-19—H. P. Co.—1000 Rks.

101-001 ✓ D 85551

D 85551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1639 W. Calhoun ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Rice

(a) RESIDENCE. No. 1639 W. Calhoun ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie Rice

6 DATE OF BIRTH (month, day, and year) Sept 26-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter on Boat

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co Md (State or country)

PARENTS

10 NAME OF FATHER Frank Rice

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. Md (State or country)

12 MAIDEN NAME OF MOTHER Sophia Skriggs

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co Md (State or country)

14 Informant Nannie Rice (Address) 1639 W. Calhoun

15 Filed APR 3 - 1924 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1924, to April 2, 1924, that I last saw h[illegible] alive on April 2, 1924 and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Smith, M. D.

(Address) April 4 1924 North Ave & Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Island Creek. Calvert Co. Md.

DATE OF BURIAL April 4 1924

20 UNDERTAKER Mrs James H. Dennis

ADDRESS 1303 Freestman St

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

85552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85552

D 85552

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2706 Chelsea Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Duncan Bedell

(a) Residence No. Salamanca N.Y. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of [illegible] Alice Bedell

6-DATE OF BIRTH (month, day and year) Sept 1861

7-AGE. 62 yrs. 7 mos. 2 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Wholesale & Retail Tobacco

(b) General nature of industry, business, or establishment in which employed (or employer)..... Merchant

(c) Name of employer..... Not Known

9-BIRTHPLACE (city or town) (State or Country). Not Known

PARENTS.

10-NAME OF FATHER. Richard Bedell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Not Known

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14-(Informant) Mrs E. J. Bennett

(Address) 2706 Chelsea Terrace

15-Filed APR 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 28 1924 to Apr. 8 1924

that I last saw him alive on Apr. 3 1924

and that death occurred, on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - myocarditis

High blood pressure

(Duration) 9 yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) Apoplexy:

(Duration) ..... yrs. ..... mos. 4 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Walter Tilbert, M. D.

Apr. 3, 1924 (Address) 2220 Harrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Salamanca N. Y. DATE OF BURIAL. April 7 1924

20-UNDERTAKER. Joo Joesolens & Son ADDRESS 217 S. Paca st.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-24—M&T—100 Blks.

D 85553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+165

REGISTERED No. D 85553

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME Murley Fisher

(a) RESIDENCE NO. Barrow ST., Baltimore, Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Fisher

6 DATE OF BIRTH (month, day, and year) Dec 11, 1897

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Daniel Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Julia Devore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Kenton Allen
(Address) 1102 Presstman

15 ROBERT N. KRAUTER, Registrar.

APR 4 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Acute Miliary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis Chronic

(duration) yrs. mos. ds.

(Signed) W. H. Worthington, M. D.
(Coroner.)

April 4, 1924 (Address) 1129 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., 11 days mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel Cemetery — DATE OF BURIAL April 6 1924

20 UNDERTAKER J. F. Echard — ADDRESS Reisterstown Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—12-23-21—E.B.R.S.—400 Blks.

D 85554

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85554

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

City of BALTIMORE, (No. 2333 Division St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Lawrence Hill

(a) Residence No. 2333 Division St, Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, Col | 5-Single, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 8. 1924

7-AGE yrs. 2 mos. 25 ds. | If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Eugene Potter

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Bertha Hill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Bertha Hill

(Address) 2333 Division St

15- APR 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 1, 1924 to Apr 3, 1924

that I last saw h~~e~~ alive on Apr 3 1924

and that death occurred, on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Indefinite

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) P. G. Chatfield M. D.

Apr. 3, 1924 (Address) 1324 E. Fayette

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 4-4-1924
Mt Auburn Cem	
20-UNDERTAKER, David Eastern	ADDRESS 916 Park Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 72656 D 85555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-00 D 85555

1-PLACE OF DEATH — JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clyde Brown

(a) RESIDENCE NO. 668 Eutaw St ST., ... WARD N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Sam Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Priscilla Tilden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 4 1924 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 25, 1924, to Mar 30, 1924, that I last saw h[illegible] alive on Mar 30, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis

Myocardial Insufficiency

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R Bagg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilson, N. C.

DATE OF BURIAL 4-5-24

UNDERTAKER Wm Eagles

ADDRESS 416 Bennett

Spec—12-23-21—E.P.R.S.—400 Bks.

85556

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 85556

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1869 N. Gay St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Louis Rock

(a) Residence No. 1869 N. Gay St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Rock

6-DATE OF BIRTH (month, day and year) Dec 7 1863

7-AGE. 61 yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.
10-NAME OF FATHER, Aug Peters
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Dont Know
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-(Informant) Louis Rock
(Address) 1869 N. Gay St.

15- APR 4 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 9 1923 to April 2 1924
that I last saw h... alive on April 2 1924
and that death occurred, on the date stated above, at 1:10 P.M.
The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frederick E. Kerns, M. D.
Apr 3 1924 (Address) 1301 Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Dallo Cemetery — DATE OF BURIAL, Apr 5 1924

20-UNDERTAKER, John Ullrich — ADDRESS 2008 Eden

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85557

CERTIFICATE OF DEATH.

REGISTERED NO. 412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 E. Fayette ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie May Bankes

(a) RESIDENCE NO. 2228 E. Fayette ST., ...WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Wm M. Bankes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Annie J. Garrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Wm M. Bankes

(Address) 2228 E. Fayette st.

15 Filed APR 4 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 14 1923 to April 1st 1924.

that I last saw h— alive on April 1st 1924

and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Cystitis Pyelonephritis

Bilateral Pyelitis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Renal Paralysis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Arthur C Hearn M. D.

4/2, 1924 (Address) 3701 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cem	4/4/24
20 UNDERTAKER	ADDRESS
W. E. Black & Son	Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85558

CERTIFICATE OF DEATH.

47 D 85558

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 E. Eager ST.: 10 WARD)

2-FULL NAME Nicholus Halblieb

(a) RESIDENCE. No. 1101 E. Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced (write the word)
male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Molder

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Nicholus Halblieb

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Smith

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant William Kaumann

(Address) 1101 E. Eager

APR 4 - 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924 19

17

I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1923, to April 2, 1924,

that I last saw him alive on april 2, 1924.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Avery, M. D.

, 19 (Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 5th 1924
20 UNDERTAKER	ADDRESS
Johannah Carolus	1007 Pitcairn st

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85559

CERTIFICATE OF DEATH.

44 D 85559

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1149 Ridgely ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aileen M. East.

(a) RESIDENCE No. 1149 Ridgely ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	42	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Helper

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry P. East

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Emma Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Annie Reed

(Address) 1149 Ridgely St

APR 4 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 19 24

17

I HEREBY CERTIFY, That I attended deceased from Jan 6 19 24, to Apr 3 19 24.

that I last saw h[illegible] alive on Apr 3 19 24,

and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of abdomen

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Fay Jones M. D.

, 19 (Address) 900 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	April 7th 1924
20 UNDERTAKER	ADDRESS
E. Schlosser & Son	1039 Hanover

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Page 166 May 3010

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85560

CERTIFICATE OF DEATH.

46 D 85560

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Calvert & 31st St Calvert Court Apt. 17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Marie Armstrong

(a) RESIDENCE NO. Calvert Court Apt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871-3-3

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Kindergartner
(b) General nature of industry, business, or establishment in which employed (or employer) 068
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS
10 NAME OF FATHER Victor C Armstrong
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Henrietta Merryman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henrietta Armstrong
(Address) Calvert Court apts

APR 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from April 3rd. 1923. to April 2nd. 1924.
that I last saw h[illegible] alive on April 2nd. 1924
and that death occurred, on the date stated above, at 6:15 a. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Adeno-Carcinoma
of at least 2 year duration
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Pernicious Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x
Did an operation precede death? No Date of x
Was there an autopsy? No
What test confirmed diagnosis? Microscopic examination
(Signed) Palmer C. Pratt, M. D.
April 3rd, 1924 (Address) 1703 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 5th 24
20 UNDERTAKER Henry W Jenkins & Son Co	ADDRESS Orchard & Mc Colloch

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85561

CERTIFICATE OF DEATH.

90

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1608 Eutaw Place ST. 14 WARD)

2-FULL NAME Effie Elliott Johnston Jenkins

(Residence in Baltimore: No. 1608 Eutaw Place

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 25 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~SINGLE,~~ MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, January 17, 1866 (Month) (Day) (Year)

7-AGE, 58 yrs. 2 mos. 30 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Quarter Ga

PARENTS.

10-NAME OF FATHER, Col R M. Johnston

11-BIRTHPLACE OF FATHER (State or Country), Ga

12-MAIDEN NAME OF MOTHER Mary F. Mansfield

13-BIRTHPLACE OF MOTHER (State or Country), Con.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lou M. Jenkins

(Address) Oakland & McCulloh Sts

15- Filed APR 4 - 1924, 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Cl

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 3rd, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy (Coroner.) M. D.

April 4, 1924 (Address) 2402 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery | DATE OF BURIAL, April 5, 1924

20-UNDERTAKER Henry H Jenkins & Co | ADDRESS Oakland & McCulloh Sts

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85562

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-0 D 85562

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 60 1 Bartlett St (W.)

2-FULL NAME Irene C. Kuhlhoff

(a) RESIDENCE. No. 60 1 Bartlett St (W.) WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Edw. Kuhlhoff

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Lake

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Edw Kuhlhoff (Address) 60 Bartlett

15 [illegible]

APR 4 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 27 1924, to Apr 3 1924, that I last saw h alive on Apr 3 1924, and that death occurred, on the date stated above, at 10 30 P.M.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) mos. ds.

18 Where was disease contracted if not at place of death? Mercy

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Burnstock M. D.

(1924 Address) 1501 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	April 4th 1924

20 UNDERTAKER Leo G. Cook ADDRESS North & Harford

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 85563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 101-001 D 85563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 East ST.; 5 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John C. Stubbs

(Residence in Baltimore: No. 523 East St.; 10 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M — Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, March ....., 1879
(Month) (Day) (Year)

7-AGE, 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work [redacted]er
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Glouster Co. Va.

PARENTS.

10-NAME OF FATHER, Corben Stubbs.

11-BIRTHPLACE OF FATHER (State or Country), Glouster

12-MAIDEN NAME OF MOTHER Fannie Burton.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Douglas Stubbs

(Address) 528 East St.

15-
Filed ....., 191.....
Registrar.

APR 4 1924

APR 4 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 31 1924, to April 1 1924, that I saw h[im] alive on April 1 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Hornstein M. D.

4/2, 1924 (Address) 733 Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Clay Bank. Glouter Co. Va.

DATE OF BURIAL, ..., 191...

20-UNDERTAKER Saml T. Hemsley.

ADDRESS 578 W Biddle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85564

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 Argyle Ave St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rebecca Williams

(a) Residence No. 1219 Argyle Av St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1860.

7-AGE.	If LESS than 1 day.
64 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None dnd

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Charleston
(State or Country), W. Va.

PARENTS.

10-NAME OF FATHER, George Harris.

11-BIRTHPLACE OF FATHER (city or town) Va.
(State or Country),

12-MAIDEN NAME OF MOTHER, Elizabeth Taylor.

13-BIRTHPLACE OF MOTHER (city or town) Va.
(State or Country),

14- (Informant) Mary Watkins?
(Address) 1219 Arygle Ave.

15- APR 4 - 1924

16- Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 7, 1924 to April 1, 1924

that I last saw h. alive on March 31 1924

and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Sciatic Neuritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

4/1, 1924 (Signed) H S M Card M. D.

(Address) 2005 Arnold Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. AuBurn CeM.	4/4/24 19....
20-UNDERTAKER.	ADDRESS
Sam'l. T. Hemsley.	578 W. Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Cor.—1-12-23—M&T—100 Bks.

D 85565 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85565

CERTIFICATE OF DEATH. +57

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Clark

(a) RESIDENCE NO. 412 C. ST. Sparrows Pt ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jay Clarke.

6 DATE OF BIRTH (month, day, and year) June 17/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville, Md.
(State or country)

PARENTS

10 NAME OF FATHER Cornelius Burton

11 BIRTHPLACE OF FATHER (city or town) MD.
(State or country)

12 MAIDEN NAME OF MOTHER Kate Dorsey

13 BIRTHPLACE OF MOTHER (city or town) MD.
(State or country)

14 Informant Jay Clarke (Address) 503 Baker St

15 Filed APR 4 - 1924 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia (Lobular)

(Autopsy at Hopkins Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cotton M. D.
(Coroner.)

Apr 3/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Star Cem. Catonsville.	4-4 192 24
20 UNDERTAKER Samuel Stansbury	ADDRESS 78 Bond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 85566

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Holtzman

(a) RESIDENCE NO. 25 N. Broadway ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Holtzman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Leurs (Address) 1439 E Balto St

15 APR 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/24

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1924, to 4/3, 1924, that I last saw her alive on 4/3, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Horace M Kerr, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/4 1924

20 UNDERTAKER Jack Leurs 1439 E Balto St — ADDRESS

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 85567

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 85567

Registered No.....

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 324 Illchester Av St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie H. Troll Paine

(a) Residence No. 324 Illchester Av. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 13. 1856

7-AGE 68 yrs. 1 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Brooklyn N Y

PARENTS.

10-NAME OF FATHER Francis Troll

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Austria

12-MAIDEN NAME OF MOTHER Kate Kraus

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Austria

14-(Informant) Louis A. Paine

(Address) 1869 Ruppert St Jamaica Queens

15-APR 4 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/4/24

17- I HEREBY CERTIFY, That I attended deceased from 3/20 1924 to 4/3 1924

that I last saw h[illegible] alive on 4/3/24 19.....,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Double Bronchio-Pneumonia

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Hyp. & Enlarged Heart

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination of Chest during Life

(Signed) J. Carroll M. D

, 19 (Address) 1740 E. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Brooklyn New York	April 4. 1924
20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	1811 W Royalare

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85568

CERTIFICATE OF DEATH.

74-09

1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 Park ave St., 14 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Schnauffer

(a) Residence No. 1518 Park Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 10 1873

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Wm. Schnauffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER Elisabeth Mobst

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Lillie Schnauffer

(Address) 1518 Park ave

15-

APR 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3-1924

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to April 3, 1924, that I last saw her alive on April 2, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Jas. McLernghill M. D.

, 19 (Address) 1800 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Apr 5, 1924

UNDERTAKER. John O. Mitchell ADDRESS 1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85569

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85569

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Oakland Ave., 27 WARD)

2-FULL NAME Michael E McDonnell

(a) RESIDENCE NO. 512 Oakland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen. McGann.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72.			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Retired Iron.

(b) General nature of Industry, business, or establishment in which employed (or employer) B & O R R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. McDonnell

(Address) 512 Oakland Ave

15 APR 4 - 1924 ROBERT N. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to April 3, 1924.

that I last saw h[illegible] alive on April 3, 1924;

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Clinical

(Signed) N. W. Wheeton, M. D.

, 19 (Address) 4235 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Apr. 1924
20 UNDERTAKER Edgar Townsend Sons	ADDRESS
Edgar Townsend	Govans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

MANIERIE

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85570

CERTIFICATE OF DEATH.

159-007 ✓ D 85570

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Burgundy 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Manneiie

(a) RESIDENCE NO. 807 Burgundy ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 11, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jas Manneiie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Thalman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Jas Manneiie

15 APR 4 - 1924 Filed , 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 3, 1924, to Apr 3, 1924,

that I last saw h alive on Apr 3, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Ungovernable) Patent Foramen Ovale

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Carmichael, M. D.

Apr 4 1924 (Address) 1038 N Wheaton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 4 1924
20 UNDERTAKER	**ADDRESS**
J J Fahey & Sons	318 Eighth

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 85571

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Aliceanna ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Lena Niedzwiecki

(a) RESIDENCE NO. 1723 Aliceanna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of Casimir Niedzwiecki

6 DATE OF BIRTH (month, day, and year) 3/16 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homework. 137

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacob. Kucinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Casimir Niedzwiecki

(Address) 1723 Aliceanna St

15 Date APR 4 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to April 1, 1924

that I last saw her alive on April 1, 1924

and that death occurred, on the date stated above, at 8-20 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Chas. L. Niles, M. D.

4/7. 1924 (Address) 408 S Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 4/5 1924

UNDERTAKER Wm. Fiedorowicz

ADDRESS 118 Eastern

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85572

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D 85572

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3328 Edmondson Ave. 16 WARD)

2-FULL NAME Christian H. Stagge

(a) RESIDENCE NO. 3328 Edmondson Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Stagge

6 DATE OF BIRTH (month, day, and year) Mar 21 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	79	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Oil

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Moulder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Don't Know.

11 BIRTHPLACE OF FATHER (city or town) Do (State or country)

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) Do. (State or country)

14 Informant Henry Stagge

(Address) 3328 Edmondson Ave

15 APR 4 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to April 2, 1924.

that I last saw h alive on April 2, 1924.

and that death occurred, on the date stated above, at 5.45 P, m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. J. T. Kenney M. D.

April 3, 1924 (Address) 280 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Apr 5 1924
20 UNDERTAKER	**ADDRESS**
Mrs Mrs. John W. Teufel & Son	801 W. Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

D 85573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85573

CERTIFICATE OF DEATH.

REGISTERED No. C 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 N Fulton Ave ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen E. Garrettson

(Residence in Baltimore: No. 1107 N Fulton Ave St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, March (Month) 10th (Day), 1850 (Year)

7-AGE, 74 yrs. 0 mos. 28 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE, (State or Country), Fallston Md

PARENTS.

10-NAME OF FATHER, Daniel Whitson

11-BIRTHPLACE OF FATHER (State or Country), Fallston Md

12-MAIDEN NAME OF MOTHER E. Spredden

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Garrettson

(Address) 1107 N. Fulton Ave.

APR 4 - 1924

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 3rd (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mch 4 1924, to Apr 3 1924, that I saw h er alive on Apr 2 1924, and that death occurred, on the date stated above, at 4 15 m.

The CAUSE OF DEATH* was as follows:

Diabetes Coma

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) ½ yrs. mos. ds.

(Signed) M. Bauman and Hoech M. D.

Apr. 4, 1924 (Address) 6 E. La. N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cem

DATE OF BURIAL, 4-5th, 1924

20-UNDERTAKER ROBERT BROOKS & SON

ADDRESS FUNERAL DIRECTORS & EMBALMERS S. E. CORNER CALHOUN & HOLLINS STREETS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85574

CERTIFICATE OF DEATH.

4129 D 85574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret McEwan

(a) RESIDENCE NO. 45 Admiral Blvd - ST., Dundalk - Md WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Mr. William McEwan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 27

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER — ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Records Johns Hopkins Hosp.
(Address)

15 Filed APR 4 - 1924 Robert P. Harrison, Registrar
. 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1924, to April 2, 1924,

that I last saw her alive on April 2, 1924,

and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with hypertension and myocardiac degeneration - Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia -

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy findings

(Signed) Fred. T. Allen, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apl 5 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec– 12-23-21—E.B.R.S.—400 Eks.

D 85575

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 85575

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest D. Pope

(a) Residence No. 3815 Eastern ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 11, 1892

7-AGE. 31 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Iron Welder

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) Oxford, Md (State or Country),

PARENTS.

10-NAME OF FATHER, Wilmer S. Pope

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Addie L. Morris

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country),

14- (Informant) Municipal Hospital Board

(Address)

15- Filed Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-3-24

17- I HEREBY CERTIFY, That I attended deceased from 3-31 1924 to 4-3 1924

that I last saw h~~im~~ alive on 4-3 1924

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Acute & Chronic

Alcoholism 9

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & history

(Signed) Claude G. Drane M. D.

4-4, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London Park	April 5, 1924
20-UNDERTAKER, John F. Denny	ADDRESS 715 Light St

PR 4-1924 Burial Permit Clerk.

P. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85576

CERTIFICATE OF DEATH.

74-00 D 85576

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary agnes Murray

(a) RESIDENCE No. 726 ajax alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER John Dorsey

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Nancy Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Municipal Hospital Records (Address)

APR 4 Filed 1924 . 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-10, 1922 to 4-1, 1924

that I last saw her alive on 4-1, 1924

and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Myocardial Insufficiency

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Drane M. D.

4-1, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL April 5 1924

20 UNDERTAKER Mrs J. G. Locke

ADDRESS 1302 Fulton

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 12

D 85577

D 85577

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

1 PLACE OF DEATH

County ..... D 85577

Village or City Baltimore (No. 2746 N. Calvert St. Ward) 12

2 FULL NAME Catherine Kohlhepp

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH Nov. 13, 1857 (Month) (Day), 1 (Year)

7 AGE 66 yrs. 4 mos. 20 ds. If LESS than 1 day, ... hrs. OR ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Von Dran

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Maria

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anthony Kohlhepp

(Address) 2746 N. Calvert St

15

Filed 191

Robert P. Harrison, Registrar

APR 4 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 3d (Month) (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1923, to April 3d, 1924,

that I last saw her alive on April 3, 1924

and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder
Liver

(Duration) yrs. 9 mos. ..... ds.

Contributory Secondary Asthenia Pernicious Anemia (metastases) Cholemia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Joseph Elguchin M. D.

April 3, 1924 (Address) 1516 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery — **DATE OF BURIAL** Apr. 5, 1924, 191

20 UNDERTAKER Henry W. Mears & Son — **ADDRESS** 805 Calvert St.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85578 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1214 N Stricker St St., 16 Ward) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Francis Ryan

(Residence in Baltimore: No. 1214 N Stricker St St., 45 yrs., ... mos., 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March 20 1879 (Month) (Day) (Year)

7-AGE. 45 yrs. ~ mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer): 0.57

9-BIRTHPLACE. (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER. Henry Ryan

11-BIRTHPLACE OF FATHER. (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER. Ellen Cadogan

13-BIRTHPLACE OF MOTHER. (State or Country) Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Ryan

(Address) 1214 N. Stricker St.

15- Filed APR 4 1924 192.... Robert P. Harrison, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 2, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Hennessy M. D. (Coroner.)

April 3 1924 (Address) 250 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Wood Lawn	April 5 1924
20-UNDERTAKER.	ADDRESS
M Tuskey & Son	827 W North

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85579

CERTIFICATE OF DEATH.

192

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 38 WARD)

2-FULL NAME Annie Burns (or Alphonsine)

(a) RESIDENCE NO. Mt Hope Retreat ST. 38 WARD Phila Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? Born yrs. Known ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	62	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 65

(b) General nature of industry, business, or establishment in which employed (or employer) Religious work

(c) Name of employer

9 BIRTHPLACE (city or town) (?)
(State or country) Ireland

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Devine

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Ireland

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md

15 APR 4 - 1924 Robert F. Harris
, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3rd 1924

17

I HEREBY CERTIFY, That I attended deceased from Mch 29, 1924, to Apr 3rd, 1924, that I last saw h[illegible] alive on Apr 3rd, 1924 and that death occurred, on the date stated above, at 4:25 P. m.

The CAUSE OF DEATH* was as follows:

Sudden.
Coronic Thrombus.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Mania Exhaustion

abt (duration) 0 yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Phila Pa.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Coronic Thrombus.

(Signed) Frank J. Cammann M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestnut Hill, Pa

DATE OF BURIAL april 6. 1924

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St

Spec.—1-10-21—M&T—1500 Bks.

OK. JTK Formel

D 85580 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85580

CERTIFICATE OF DEATH. 12 Cor. W. D.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Beyer

(a) RESIDENCE NO. 118 Addison St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? 40 yrs. 5 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mattie R. Barker

6 DATE OF BIRTH (month, day, and year) Sept. 29-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	5	5	

8 OCCUPATION OF DECEASED Driver

(a) Trade, profession or particular kind of work Balto Transfer Co

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Gottfried Beyer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Susanna Baumgardt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Edw. Beyer
(Address) 112 Oak

15 Robert P. Harrison, Registrar
APR 4 - 1924 .19 ~~Burial Permit Clerk~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31st, 1924, to April 4th, 1924,

that I last saw him alive on April 4th, 1924,

and that death occurred, on the date stated above, at 12:20 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

Adenitis, right thumb (over)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hospital & Lab. findings.

(Signed) James F. White, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cem. Violetville

DATE OF BURIAL Apr 7 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1424 W. North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85581

CERTIFICATE OF DEATH.

100-D 85581

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2742 E. Baltimore St., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ethan Allen Beardsley

(a) RESIDENCE NO. 2742 E. Balto. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shirt Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm @ Beardsley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma -------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant J. A. Moran
(Address) 3000 E Balto. St

15 Filed APR 5 -1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congestion, Lungs

(duration) yrs. mos. ds.

(Signed) J. S. H. Pates, (Coroner) M. D.

Apr 4 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4/5 1924

20 UNDERTAKER J. A. Moran

ADDRESS 3000 E Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85582

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85582

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 N Potomac St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Lofranela

(a) Residence No. 614 N Potomac St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cantor Lofranela

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

11- (Informant) Frank Lofranek

(Address) 614 N Potomac St

12- Filed APR 5 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4-3-24

17- I HEREBY CERTIFY, That I attended deceased from 1-2 1924 to 4-3 1924

that I last saw h alive on 4-2 1924

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

3

(Duration) yrs. mos.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. Fred Rovicky M. D.

4-4-24 (Address) 606 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL. June 5 1924

20-UNDERTAKER. Frank Tarabochia — ADDRESS 1906 Eastlake

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85583

CERTIFICATE OF DEATH.

D 85583

REGISTERED NO. 179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 Linden St. Edmonston WARD)

2-FULL NAME Grace Edmonston

(a) RESIDENCE NO. 1414 Linden St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

009

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER L. H Edmonston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ida Pool

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant L H Edmonston (Edmonston) (Address) 1414 Linden

15 APR 5 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1924

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1922, to April 4, 1924,

that I last saw h alive on April 3, 1924,

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones, M. D.

4-4 1924 (Address) 22 Chew Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 6th 1924

20 UNDERTAKER Chas E. Brandt

ADDRESS 502 Madison Av

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85584

CERTIFICATE OF DEATH.

D 85584

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 12 WARD)

2-FULL NAME John R. Parker

(a) RESIDENCE NO. 2721 Huntington ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Nellie E. Parker.
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steam Shovel Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) 030
(c) Name of employer Myers.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. J. R. Parker
(Address) 2721 Huntington ave

15 Filed APR 5 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute Nephritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 14 ds.

(Signed) J. E. Hennessy, M. D.
(Coroner)

April 2, 1924 (Address) 2780 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL Apr 5 1924

20 UNDERTAKER A. S. Marshall ADDRESS 3539 Gall Rd.

MARGIN RESERVED FOR FILING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85585

CERTIFICATE OF DEATH.

172

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rev James Guardi

(Residence in Baltimore: No. 111 N Hilton St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Phillip Guardi

11-BIRTHPLACE OF FATHER. (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Anna M.

13-BIRTHPLACE OF MOTHER. (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Louis James

(Address) 111 N Hilton St

15- APR 5 1924 Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia
Following Fracture R. Leg
Hypostatic Congestion and Oedema of Lungs
Contributed to Death
(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Faulon M. D.
(Coroner.)

4/4 1924 (Address) Tower Chambers

State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)
At place of death ..... yr. ..... mos. 4 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

111 N Hilton St

Former or usual residence 111 N Hilton St

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

New Cathedral Cem. April 7 1924

20-UNDERTAKER. ADDRESS

Wm Cook 512 E North Ave

Burial Permit Mark

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85586

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1505 W Lexington St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Spengler

(Residence in Baltimore: No. 1505 W Lexington St. ...yrs. ...mos. ...ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS MUST state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH. July (Month) 4 (Day) 1850 (Year)

7-AGE. 73 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jacob J. Joh

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Louise E Roesler

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena L Spengler

(Address) 1505 W Lexington

15-

Filed ..... 192.....

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

APR 5 - 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Hanlon M. D. (Coroner.)

April 11 1924 (Address) 7 W E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	April 7 1924
20-UNDERTAKER,	ADDRESS
William Cook & Son	E Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

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D 85587 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2742 N Charles St., 17 Ward) Registered No. 92

2-FULL NAME Priscilla Jane Snyder

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2742 N. Charles St., 17 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 82 yrs. 0 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Snyder

6-DATE OF BIRTH (month, day and year) Mar-25-1842

7-AGE, 82 yrs. 0 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Davidsonville A.A. Co. Md.

PARENTS.

10-NAME OF FATHER, Benj. Claggett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), A.A. Co Md.

12-MAIDEN NAME OF MOTHER Sarah Watkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), A.A. Co. Md.

14- (Informant) Walter C. Snyder Sr. (Son)
(Address) 304 St. Paul St. City.

15- Filed APR 5 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 2-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Apr. 2, 1924, that I last saw her alive on Apr. 2, 1924 and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis
Cerebral arteriosclerosis
(Left hemiplegia.
(Duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Coronary arteriy Thrombosis
(Duration) yrs. mos. 1/24 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Alan Constable, M. D.
, 19 (Address) 1107 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cemetery

DATE OF BURIAL, Apr 5, 1924

20-UNDERTAKER J. H. MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS In plain terms, so that it may be properly classified. Exact statement of OCCU instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85588

CERTIFICATE OF DEATH.

162 D 85588

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 E. Madison St ST., 10 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Vernon Gaines

(a) RESIDENCE No. 1114 E Madison St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 4/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Walter E. Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Edith E. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Walter E. Gaines
(Address) 1114 E. Madison St

15 Filed APR 5 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to hjs death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from bowels

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) unknown (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Bauer, M. D. (Coroner.)

Apr 5/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	April 5 1924
20 UNDERTAKER	ADDRESS 1631
Edward Bryan	orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85589

CERTIFICATE OF DEATH.

49

D 85589

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Davis

(a) Residence No. 513 Parish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 10 01

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Dallas Davis

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed APR 5 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-3-24

17- I HEREBY CERTIFY, That I attended deceased from 3-24, 1924, to 4-3, 1924 that I last saw him alive on 4-2, 1924 and that death occurred, on the date stated above, at 3-30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(Duration) yrs. 3 mos. (Autopsy) ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Chace, M. D.

4-3, 192 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 5, 1924
20-UNDERTAKER.	ADDRESS
Sam'l W. Chace Son	1400 Mosher

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85590

CERTIFICATE OF DEATH.

16-D 85590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 X 8 Baker ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Selma Williams

(Residence in Baltimore: No. 5 X 8 Baker St.; .....yrs., ...mos. .....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	C	Single

6-DATE OF BIRTH, 4/4 (Month) (Day), 1924 (Year)

7-AGE, 2 hrs. .....yrs.....mos.....ds. If LESS than 1 day, 2 hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas Williams

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Selma Snell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Selma Snell.

(Address) 5 X 8 Baker St.

15-

Filed APR 5 1924, 191.....

Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4/4 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/4 1924, to 4/4 1924, that I saw h[illegible] alive on 4/4 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

6 mos Marasmus at about 6 p.m.
Died because of premature birth about
8 p.m. 4/4 Suffering from Injuries in Working
Cause of Marasmus (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)
..... (Duration).....yrs.....mos.....ds.

(Signed) Burkhart M. D.

4/5, 1924 (Address) 2139 Ash St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	4-5, 1924
20-UNDERTAKER George J. A. Gibson	ADDRESS 1735 Druid Hill Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

Julia Mrozinska,

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85591

CERTIFICATE OF DEATH.

11-60

D 85591

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 S. Bethel ST.: V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Mrozinska

(a) RESIDENCE. No. 602 S. Bethel ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27 - 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nicholas Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Julia Mrozinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Julia Mrozinski, Mother
(Address) 602 S. Bethel St.

15 Filed APR 5 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-25 1924 to 4-4 1924.

that I last saw h alive on 4-3 1924

and that death occurred, on the date stated above, at 11.20A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? maternity

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Bruno Eby M. D.

(Address) 800 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cem.,	Apr. 5th 1924
20 UNDERTAKER M. J. Sadowski.,	ADDRESS 705 S. Ann

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85592

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 648 Raborg st ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Ida Nash

(a) RESIDENCE NO 648 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

~~widowed~~

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto and
(State or country)

PARENTS

10 NAME OF FATHER Wm. J. Nash

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Countryar Md

12 MAIDEN NAME OF MOTHER Ella Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Countryar and

14 Informant Ida Nash
(Address) 648 Raborg st

Filed APR 5 1924 192

Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy,~~ or inquiry.)
thereon and from the evidence obtained by said ~~(Inquest, au-~~ ~~topsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Valvular Disease of the Heart

(duration) Dont Know mos ds.

CONTRIBUTORY (Secondary) Dont Know
(duration) yrs. mos. ds.

(Signed) A K Gough M. D.
(Coroner.)

4 4 , 1924 (Address) 117 N Dawson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	April 5 1924
20 UNDERTAKER	ADDRESS
Jno Gerth Hoffa	406 W Lom

NAME CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85593

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85593

CERTIFICATE OF DEATH.

4/16-24

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Anderson

(a) RESIDENCE NO. 22 Cypress St Canton Bast WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3 1924

7 AGE Years Months Days If LESS than 1 day 21 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Ole Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Lilly Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant: Mother (Address)

15 Robert P. Harrison, 19 Registrar

APR 5 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1924

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to April 4, 1924, that I last saw him alive on April 4, 1924, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (32 weeks foetus)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin Rees, M. D.

4/4 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. A. Co. DATE OF BURIAL 4/5 1924

20 UNDERTAKER: Margaret J. Flynn ADDRESS 1417 Eight St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85594

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 4 St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Brangle

(a) Residence No. 423 W. Saratoga st. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6-DATE OF BIRTH (month, day and year): 1851

7-AGE.	If LESS than 1 day,
73 yrs. ..... mos. ..... ds.	..... hrs. or ..... min. ?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman 66

(b) General nature of Industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: .....

9-BIRTHPLACE (city or town) ..... (State or Country), West virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

APR 5 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 3 1924 to April 4 1924

that I last saw him alive on April 4 1924

and that death occurred, on the date stated above, at 11.10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) L. A. Lally, M. D

4-4-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Country	April 7th 1924
20-UNDERTAKER.	**ADDRESS**
William W. Shreve	1018 Edmondson Ave.

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85595

CERTIFICATE OF DEATH.

74 801 D 85595

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3-E-Lee St ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Dennis

(a) RESIDENCE NO. 3-E-Lee St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. A. Dennis

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Moreland Co. Pa

PARENTS

10 NAME OF FATHER: Gov. Strawn

11 BIRTHPLACE OF FATHER (city or town) (State or country): West Moreland Co. Pa.

12 MAIDEN NAME OF MOTHER: Minnie Crawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Moreland Co Pa.

14 Informant: Mabel Dennis

(Address) 3 E. Lee St City

15 Filed APR 5 1924, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924. to April 3, 1924.

that I last saw her alive on April 2, 1924.

and that death occurred, on the date stated above, at 3.35A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bright Disease & Complications Diseases (duration) yrs. 3 mos. 10 ds.

18 Where was disease contracted if not at place of death? A. A. Co. Md.

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr S W Kinnard, M. D.

4-3, 1924 (Address) 704 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magothy A. A. Co Md	4/6 1924
20 UNDERTAKER	ADDRESS
Jas. W. Kinnard	625 E. Mad St

Cor.—1-12-23—M&T—100 Bks.

D 85596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2728 Edmondson Ave ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vanna Taylor

(a) RESIDENCE NO. 2728 Edmondson Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. V. Frieda Taylor.

6 DATE OF BIRTH (month, day, and year) July 2, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69 yrs.	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer) (Farmer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. R. Carruthers
(Address) 2728 Edmondson ave.

15 APR 5 - 1924 Robert P. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

April 2, 1924 (Address) 28 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL April 5 1924

20 UNDERTAKER George J. Smith — ADDRESS 1532 Hollins St

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85597

CERTIFICATE OF DEATH.

94-801

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2245 N. Fulton Ave. ST., 19 WARD)

2-FULL NAME Mrs Emma E. Murdon

(a) RESIDENCE No. 530 D. Pendleton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. A. Murden

6 DATE OF BIRTH (month, day, and year) 5/31/1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Dyer

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mr. Mary Cole
(Address) 2245 N. Fulton Ave

15 Filed ... 19 ... Robert F. Harrison, Registrar

APR 5 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch 26th, 1924, to Apr 3rd, 1924,

that I last saw her alive on Apr 2nd, 1924,

and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos 8 ... ds.

CONTRIBUTORY (Secondary) Age & Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 2245 N Fulton Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Concussion

(Signed) ... M. D.

4/3, 1924 (Address) 1605 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 5 1924

20 UNDERTAKER George J. Smith

ADDRESS 1532 Hollins

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85598

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 85598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thompson

(a) RESIDENCE No. 1701 Presbury ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31 - 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER William Berns

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U S A.

12 MAIDEN NAME OF MOTHER Violet Thompson

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md.

14 Informant .....
(Address) .....

Filed ..... 19 ..... Registrar

APR 5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1924 to Apr 4, 1924

that I last saw him alive on Apr 4, 1924,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Syphillis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) S. R Parsons, M. D.

4-4, 1924 (Address) 1702 Westwoodave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS APR 4 - 1924

Buried Forest Cem.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85599 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85599

CERTIFICATE OF DEATH. X 24-09

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 442 Orchard ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgil Coles

(a) RESIDENCE NO. from Ducain Penna ST., WARD)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: labor

(b) General nature of industry, business, or establishment in which employed (or employer): O+O

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Lathenus Coles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary J. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. L. A. Sykes

(Address): 442 Orchard Street

15 Filed APR 5 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1924, to Apr 3, 1924, that I last saw him alive on Apr 3, 1924, and that death occurred, on the date stated above, at 5-8 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard G. Fletcher M. D.

4/4, 1924 (Address) 1225 Penna Ave, City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Apr. 5 1924
20 UNDERTAKER	ADDRESS
R. C. Gross	1405 Mc Elderry St.

Rec'd per Edward Whalen

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85600 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D 85600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. 1026 Wilmer Alley St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Holland

(a) Residence No. 1026 Wilmer alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of Samuel Holland

6-DATE OF BIRTH (month, day and year) Feb 1879

7-AGE, 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) — 03

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), maryland

PARENTS.

10-NAME OF FATHER, Sam

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Samuel holland

(Address) 1026 Wilmore alley

15- Filed APR 5 - 1924 19?

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3-1924

17- I HEREBY CERTIFY, That I attended deceased from April 1st 24 to April 3rd 24

that I last saw h[illegible] alive on April 2 24

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph J Nuriel M. D.

19 (Address) 3219 Pennsylv.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel Cemetery	April 6th 1924
20-UNDERTAKER.	ADDRESS
Johnston Goodwin	1127 Pinehurst

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85601 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 85601

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Delia Handy

(a) Residence No. 821 Warren St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible] 1860

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Eastern Shore Maryland.

PARENTS.

10-NAME OF FATHER, Alton Lewis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Talbot County Maryland.

12-MAIDEN NAME OF MOTHER, Mary Lewis.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Talbot County Maryland

14- (Informant) George King

(Address) 821 Warren St

15- Filed ..... 192 Robert P. Harris Registrar.

APR 5 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/4/24

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to April 4 1924

that I last saw her alive on April 4 1924

and that death occurred, on the date stated above, at 8-A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Gangrene - R. foot

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of March 24, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Sulton M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Co Pikesville Md. DATE OF BURIAL, April 5 1924

20-UNDERTAKER, John H Todd ADDRESS 1627 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85602

CERTIFICATE OF DEATH.

129

D 85602

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 E 22 ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Lydia Summers

(Residence in Baltimore: No. 435-22nd St.; ....yrs.... ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, May (Month) 12 (Day), 1848 (Year)

7-AGE, 76 yrs. .... mos. .... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Thomas J. Pitt

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Francis Goldsborough

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Summers

(Address) 435 E 22 St

15-

Filed ...., 1924 Robert P. Harrison, M.D. Registrar.

APR 5 - 1924 Burial Permit Mar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day), 1924 (Year)

I HEREBY CERTIFY, That I attended deceased from March 1924, to April 4 1924, that I saw her alive on April 3rd 1924, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia

.....

.....

..... (Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis (Duration) 20 yrs. .... mos. .... ds.

(Signed) H. Stanley Green M. D.

4-4-, 1924 (Address) 1900 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Greenmount — DATE OF BURIAL, April 7, 1924

20-UNDERTAKER E. A. Wiedefeld — ADDRESS 501 E 22 St

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

LEWYT

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85603

D 85603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Esplanade Apt St., 13 Ward) 74

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Himmelrich Lewyt

(a) Residence No. Esplanade Apt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry S. Lewyt

6-DATE OF BIRTH (month, day and year) January 4th 1849

7-AGE. 70 yrs. 2 mos. 26 ds.

If LESS than 1 day hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Bernhard Himmelrich

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Caroline Rosenberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11-(Informant) Jay Himmelrich

(Address) Esplanade Apt

13-Filed APR 5 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3/24

17-I HEREBY CERTIFY, That I attended deceased from Mar. 1 1924 to April 3 1924

that I last saw him alive on April 5 1924

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Offutt Simpson M. D

April 1924 (Address) 1910 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: April 6 1924

20-UNDERTAKER: Harry Sondheim — ADDRESS: 1000 W. Baltimore St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85604

CERTIFICATE OF DEATH.

D 85604

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 714 N. Milton ave ST., 7 WARD)

2-FULL NAME Sarah E Saunders

(a) RESIDENCE NO. 714 N. Milton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): John Saunders

6 DATE OF BIRTH (month, day, and year): Dec 15 1848

7 AGE — Years: 76 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Abraham [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Harry Saunder

(Address): 714 N Milton ave

APR 5 1924 File ..... 19 .....

Burial Permit Clerk ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to Apr 3, 1924

that I last saw h[illegible] alive on Mar 2, 1924,

and that death occurred, on the date stated above, at 10 10 p. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis (duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E A Meyer, M. D.

4/4, 19 24 (Address) 2638 E Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem — DATE OF BURIAL: April 7 1924

20 UNDERTAKER: E A Weidefeld — ADDRESS: 501 E 22 St.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Baff) (On as much Mission)

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85605

100-001

D 85605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Zaff

(a) RESIDENCE NO. 602 W. Saratoga St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE: 50 (Years / Months / Days) If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer on Furniture Wagon

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edw. Zaff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Cath. Daub.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records (Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

APR 5 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7/24

17 I HEREBY CERTIFY, That I attended deceased from 4/1/24, 19..., to 4/4/24, 19..., that I last saw him alive on 4/4/24, 19..., and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews Cem

DATE OF BURIAL: Apr 7 1924

20 UNDERTAKER: John Ulrich

ADDRESS: 208 E Eager

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85606

CERTIFICATE OF DEATH.

11-002 D 85606

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 N. Arlington Av St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. Mackey

(Residence in Baltimore: No. 1014 N. Arlington Av St.; 5 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Nov. (Month) 4th (Day), 1899. (Year)

7-AGE, 34 yrs. 5 mos. 0 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Hutzler Bros

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Irvin Mackey

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Anna Gates

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Irvin H. Mackey

(Address) 1007 W. Lexington St.

15-

Filed APR 5 1924, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH ..... Apr. (Month) 4 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan'y 11 1924, to Apr 4 1924, that I saw h[illegible] alive on Apr 3 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Tuberculosis

..... (Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) 1 yr. ..... mos. ..... ds.

(Signed) [illegible] M.D.

Apr. 4, 1924 (Address) 1413 E. Hill St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Royal Oak Md. DATE OF BURIAL: Apr. 6, 1924

20-UNDERTAKER: Geo. M. Johnson ADDRESS 1309 Druid Hill Av.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85607 ✓

11-002

D 85607

PLACE OF DEATH

City of BALTIMORE: (No. 125 S. Spring St. 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Gordon

(a) Residence No. 125 S. Spring St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of married

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Abraham Gordon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Rose Gordon

(Address) 125 S. Spring st

APR 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 4/24

17- I HEREBY CERTIFY, That I attended deceased from March 21, 1924, to April 4, 1924

that I last saw h... alive on April 4, 1924

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. A. Michelson M. D.

4/4, 1924 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Northern Rd — DATE OF BURIAL. April 6, 1924

20-UNDERTAKER. Sol Levinson & Bro. — ADDRESS 1127 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 ✓ D 85608

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cummins

(a) RESIDENCE NO. 1329 Locust ST., WARD Pittsburg. Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Mrs Wm Cummins

6 DATE OF BIRTH (month, day, and year) Jan 15 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods
(c) Name of employer Oort

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Simon Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Sivitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

APR 6 - 1924 Filed ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20 1924 to April 5 1924
that I last saw him alive on April 5 1924
and that death occurred, on the date stated above, at 8 46 P. m.
The CAUSE OF DEATH* was as follows:

Brain tumor cerebellar malignant?

(duration) yrs. 3 mos da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of Mar. 31
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) F. H. Redlich M. D.
Apr 5, 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa — DATE OF BURIAL 4/6 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E. Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85609 ✓ D 85609

CERTIFICATE OF DEATH.

124

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospt ST., 17 WARD)

2-FULL NAME Robert S. Cunningham

(a) RESIDENCE NO. Elm Hall apt. 3401 Greenway ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Katherine Webb

6 DATE OF BIRTH (month, day, and year) May 10, 1862

7 AGE — Years: 61 — Months: 10 — Days: 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Washington, D. C.

PARENTS

10 NAME OF FATHER: Robert Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dublin, Ireland

12 MAIDEN NAME OF MOTHER: Martha Ritchie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Talapoosa, Ala.

14 Informant: Ray Cunningham (Son) (Address): 1723 Madison Ave.

15 Filed APR 6 - 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-'24 19

17

I HEREBY CERTIFY, That I attended deceased from 3-30-'24, 19..., to 4-4-'24, 19...,

that I last saw him alive on 4-4-'24, 19...,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure & pulmonary Oedema

(duration) yrs. mos 1 hour.

CONTRIBUTORY (Secondary) Cholecystostomy. (Chronic Pancreatitis) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-3-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Syph

(Signed) John A Tompkins, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. — DATE OF BURIAL: April 7th 1924

20 UNDERTAKER: Henry A Jenkins Sons Co — ADDRESS: McCulloh & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated—EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 85610

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 E Eager ST., 11 WARD)

2-FULL NAME Olivia Lee Whitehead

(a) RESIDENCE NO. 22 E Eager ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1st 1834

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or estahlishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Francis O. Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Caroline T. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant T. S. Bowles S. Boswell
(Address) 22 E Eager St

15 APR 6 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from January ..., 1922, to April 5th ..., 1924,

that I last saw her alive on APRIL 4th ..., 1924,

and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thomas L. Shearer, M. D.

Ap. 5th, 1924 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Virginia	April 6 1924
20 UNDERTAKER	ADDRESS
Henry H Jenkins Jr Co	Cleveland Ave Norfolk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85611

CERTIFICATE OF DEATH.

57 D 85611

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 3541 Liberty Heights Ave St.) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Golden

(a) RESIDENCE NO. 3541 Liberty Heights Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Golden

6 DATE OF BIRTH (month, day, and year) July 13

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	51	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professional Boxman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto-Md

PARENTS

10 NAME OF FATHER James Golden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Golden

(Address) 3541 Liberty Heights Ave

15 APR 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1924. to Apr 4 1924.

that I last saw h alive on April 4 1924.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Diabetes - Nephritis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood Chs

(Signed) Chas J Block, M. D.

Apr 5 1924 Address) 704 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 7 1924
20 UNDERTAKER J. Ahrens & Co	ADDRESS 1611 Madison Ave

Spec–12-23-21–E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85612

101-001 ✓

CERTIFICATE OF DEATH.

D 85612

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1438 Ward: 21 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bell Williams

(a) Residence No. 1438 Ward St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, Divorced (Write the word)

6-If married, widowed, or divorced, HUSBAND of (or) WIFE of W. H. Williams

6-DATE OF BIRTH (month, day and year) unknown

7-AGE 36 — yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HW.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Athen. Ga.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

14- (Informant) W. H. Williams (Address) 1438 Ward St

15- Filed APR 6 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 3 - 1924

17- I HEREBY CERTIFY, That I attended deceased from March 30 19 24 to April 3 19 24 that I last saw h... alive on April 3 19 24 and that death occurred, on the date stated above, at 7.40 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What tests confirmed diagnosis? .....

(Signed) John J. Petrowsky M. D.

19 (Address) 11 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	4-6 1924
UNDERTAKER.	ADDRESS
Daniel Easton	916 Mc Cul

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85613

CERTIFICATE OF DEATH.

101-00

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Baltimore St. 11 WARD)

2-FULL NAME Emma Green

(a) RESIDENCE NO. 924 Baltimore St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 60 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook.
(b) General nature of industry, business, or establishment in which employed (or employer) 021
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant John Stewart
(Address) 924 Baltimore St

15 Filed APR 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) H. J. Steinbach M. D.
(Coroner.)

(Address) 2902 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4-7 1924

20 UNDERTAKER Dan'l Easton

ADDRESS 916 Gay ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85614

CERTIFICATE OF DEATH.

X 43 D 85614

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 N Calvert ST., 17 WARD)

2-FULL NAME William H. Hamilton

(a) RESIDENCE NO. 2410 N Calvert ST., ... WARD West River Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 8 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0 8 6

9 BIRTHPLACE (city or town) (State or country) Westriver A.A.Co Maryland

PARENTS

10 NAME OF FATHER Samuel H Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Duvall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co Maryland

14 Informant Mrs Marmaduke Hamilton (Address) 2410 N Calvert st

15 Filed APR 6 - 1924 ROBERT R. K... Registrar

Burial Permit ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1924

17 I HEREBY CERTIFY, That I attended deceased from — 1923, to Apr 4 1924.

that I last saw h✓ alive on Apr 4 1924

and that death occurred, on the date stated above, at 10 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of May 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation & Laboratory

(Signed) Horace W. Bryan, M. D.

, 19 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	April 7, 24
20 UNDERTAKER John H Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

85615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 85615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital St., WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Burges

(a) RESIDENCE: No. Bay View Hosp St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or .. min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Bay View Hospital (Address)

15 Filed APR 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Decemb. 4, 1922 to April 3, 1924, that I last saw him alive on April 3, 1924, and that death occurred, on the date stated above, at 10 55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Epilepsy

Unkn. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bay View Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. J. Goldsmith M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 6 1924

20 UNDERTAKER ADDRESS Joseph Syfer 1600 N. Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D 85616

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 N Duncan ST., 7 WARD)

2-FULL NAME Wilhelmina Green

(a) RESIDENCE No. 510 N Duncan ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed.

5a If married, widowed, or divorced (or) WIFE of Joseph W. Green

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
approx 80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Gloucester Co Va (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Jas W Green

(Address) 510 N Duncan St

15 APR 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1923, to April 3, 1924, that I last saw h alive on April 2, 1924, and that death occurred, on the date stated above, at 12 Noon m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J ... M. D.

4/5, 1924 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: April 7 1924

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVES

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 85617

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 717 S Bond St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Kowah

(a) Residence No. 717 S Bond St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Feb 6 1923

7-AGE: 1 yrs. 1 mos. 30 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Michael Kowah

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Frances Szymanska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14-

(Informant): Michael Kowah

(Address): 717 S Bond St

15-

APR 6 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-5-24

17- I HEREBY CERTIFY, That I attended deceased from 3-21-24, 19.., to 4-5, 1924, that I last saw h[illegible] alive on 4-4, 1924, and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

Diphtheria

Broncho Pneumonia

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) T. Floyd Bowlby M. D.

4-5, 1924 (Address) 1001 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: April 6, 1924

20-UNDERTAKER: John F. Weber — ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Riley

Cor.—1-12-23—M&T—100 Bks.

D 85618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85618

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anthony J. Dobbins

(a) RESIDENCE No. 614 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 3, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	5	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Horseshoer
(b) General nature of industry, business, or establishment in which employed (or employer) 836
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James J. Dobbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary E Bourke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Agnes M Manian

(Address) 614 Aisquith Street

15 Filed APR 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Valv. dis. heart)

Broncho. adenocarcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.

Apr. 4, 1924 (Coroner.) (Address) 1059 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 4 or 5 minutes

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 4/7 1924

20 UNDERTAKER Wm Cox 16

ADDRESS Solemn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85619

CERTIFICATE OF DEATH.

90 D 85619

Registered No.....

1-PLACE OF DEATH St Josephs Hospital

City of BALTIMORE: (No. ..... St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Daisy H Weatherman

(a) Residence No. 1508 Harlem Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry G Weatherman

6-DATE OF BIRTH (month, day and year) July 5. 1882

7-AGE.	If LESS than 1 day.
41 yrs. 9 mos. ds.	hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Thomas B. S. Hoffman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER Emma Harrison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Harry G. Weatherman

(Address) 1508 Harlem Ave

15- Filed APR 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 28 1924 to April 5th 1924

that I last saw her alive on April 5th 1924

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) L. M. Corkell, M. D.

, 1924 (Address) 1114 Harlem Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Greenmount	April 8, 1924

20-UNDERTAKER	ADDRESS
W. Cook	502 E Northern

Spec—12-23-21—E.B.R.S.—400 Bks.

Burgess 1216 Penn Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85620

CERTIFICATE OF DEATH.

10 129

D 85620

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1135 Burkwood Ave. St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emily Jane Cushing

(a) Residence No. 1135 Burkwood Ave. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenzo

6-DATE OF BIRTH (month, day and year) Dec 25 1852

7-AGE,	If LESS than 1 day,
..... yrs. 3 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, James Black

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Penn

12-MAIDEN NAME OF MOTHER, Dorit Kunn

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Penn

14- (Informant) Anna B Friedgen

(Address) 1135 Burkwood Ave

15- (Filed) APR 6 - 1926

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 4 1924

17- I HEREBY CERTIFY, That I attended deceased from March 29, 1924 to April 4, 1924

that I last saw her alive on April 4, 1924

and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(Duration) 2 yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Uraemic poisoning

(Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Urinal test

(Signed) Hubert Latham, M. D.

(Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1926
Woodlawn	Apr 7
20-UNDERTAKER	ADDRESS
Wm Cook	502 E. Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69

D 85621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Purcell

(a) RESIDENCE NO. 68 East Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lottie Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

APR 6 - 1924 Filed

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 - 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2 - 1924, to April 3 - 1924, that I last saw her alive on April 3 - 1924, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic purpura

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from rhinopharynx

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Two tranfusions Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. B. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL Apr. 6 1924

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Ilks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85622

CERTIFICATE OF DEATH.

174 D 85622

1-PLACE OF DEATH Pronounced dead at St. Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 10 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine L. Reedy

(a) RESIDENCE No. 804 Willow Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx x

6 DATE OF BIRTH (month, day, and year) Janruary 2/1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Reedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine O'Brein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant H.C.Wiedefeld
(Address) 914 Greenmount Ave

15 Filed APR 6 - 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-burns over entire body clothing caught fire when she poured coal oil on fire.

Accidental (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) G. H. Vallin, M. D. (Coroner.)

Apr 5/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Augustines-Elkridge	April 7 1924
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Greenmt Av

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85623

D 85623

CERTIFICATE OF DEATH.

100-00

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Kate Fennerman

(a) Residence No. 1556 N. Fulton St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 185X

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, Md
(State or Country),

PARENTS.

10-NAME OF FATHER, John Robinson

11-BIRTHPLACE OF FATHER (city or town) Penn
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ?
(State or Country),

14- (Informant) Municipal Hospital

(Address)

15- APR 6 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-3-24

17- I HEREBY CERTIFY, That I attended deceased from 3-13 192X to 4-3 192X

that I last saw her alive on 4-3 192X

and that death occurred, on the date stated above, at 6 55 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext

(Signed) Claude A. Bruce, M. D.

4-5. 192X (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Peter's Cemetery	Mar. 7.... 1924
20-UNDERTAKER.	ADDRESS
F. A. Frame & Son	703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85624

CERTIFICATE OF DEATH.

90 D 85624

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Selma Blum

(a) RESIDENCE NO. 137 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 19-1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	9	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Goldberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to April 5, 1924, that I last saw h alive on April 5, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chr. mitral valvular disease

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chorea

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? \

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor S. Jay, M. D.

(Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 4/6 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

ABRO - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85625

CERTIFICATE OF DEATH.

D 85625

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Rayner

(a) Residence No. 2018 Alicanna st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1883

7-AGE. 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Edward Rayner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Laura Bellison

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Hospital Records

(Address) M.T.H.

APR 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 31 19 24 to April 5 19 24

that I last saw h. im alive on April 5 19 24,

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally M. D

4-5- 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL, April 7 1924

20-UNDERTAKER, John J. Fields

ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21--E.B.R.S.--400 Bks.

HEALTH DEPARTMENT, CITY OF BALTIMORE

D 85626

CERTIFICATE OF DEATH.

14 3

D 85626

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilda Forrester

(a) Residence No. 2022 Division st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1908

7-AGE.	If LESS than 1 day.
16 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, John Forrester

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Eugenia Forbes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- APR 6 - 1924 ROBERT R. KR... Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 2, '24

17- I HEREBY CERTIFY, That I attended deceased from March 10, 1924 to April 2, 1924

that I last saw h.er alive on April 2, 1924,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray. Sputum

(Signed) L. A. Lalley, M. D

4-3- 24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Auburn Cem.	4/6 24
UNDERTAKER	ADDRESS
Saml. S. Hensley	N. Bond St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85627

CERTIFICATE OF DEATH.

90 D 85627

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Mt. Auburn St., 14 WARD)

2-FULL NAME Rachel Adams

(a) RESIDENCE NO. 1721 Mt. Auburn ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.,
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Alabama
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Carrie Byrd
(Address) 1721 Mt. Auburn St.

15 Filed APR 5 - 1924, 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

April 5, 1924 (Address) 230 Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 4/6 1924

20 UNDERTAKER Saml. Hemsley

ADDRESS 1138 Baker

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21– E.B.R.S.—400 Bks.

D 85628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 129

D 85628

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2927 N. Calvert St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget McMahon

(a) Residence No. 2927 N. Calvert St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James McMahon

6-DATE OF BIRTH (month, day and year) July 24, 1842

7-AGE.	If LESS than 1 day.
81 yrs. 8 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Edward Dooley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ellen Prout

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Mrs. Henry W. Walker

(Address) 2927 N. Calvert St

15- APR 6 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 4 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15 1924 to April 4 1924

that I last saw h- alive on April 3 1924

and that death occurred, on the date stated above, at. 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Unknown
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ch. Valv. Endocarditis

Unknown
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jeffrey Buck M. D.

4/5/, 1924 (Address) 2844 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19....
Cathedral Cemetery	4/7/24
20-UNDERTAKER,	**ADDRESS**
Henry W. Mears & Son	805 Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Poist

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85629

100-001 ✓

D 85629

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Bay View Hsp. ST., 116 WARD)

2-FULL NAME Charles H - Poirot -

(a) RESIDENCE NO. Bay View Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of —

6 DATE OF BIRTH (month, day, and year) April 1-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
5	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 166

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jerome Poist

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): Hospital Records

15 Filed APR 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1924

17 I HEREBY CERTIFY, That I attended deceased from 2/12/24, 19, to 4/5/24, 19.

that I last saw him alive on 4/4/24, 19,

and that death occurred, on the date stated above, at 8. A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic psychosis of cerebral arterio sclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. Fredomith, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: April 7th 1924

20 UNDERTAKER: Peterson & Son — ADDRESS: 1220 W. Fayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85630

CERTIFICATE OF DEATH.

D 85630

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame St. 10 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Facunda Schick

(a) RESIDENCE. No. Disquith St and Ashland Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March - 10 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia Pa.
(State or country)

PARENTS

10 NAME OF FATHER John Schick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Little

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Sister Mary Dismas
(Address) Notre Dame, Disquith St.

Filed APR 6 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April - 5 - 1924

17

I HEREBY CERTIFY, That I attended deceased from January, 1924, to April, 1924, that I last saw h.s alive on April - 3 - , 1924, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis
several years.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Kirby, M. D.

April 7, 1924 (Address) 1106 Forth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Notch Bluff — DATE OF BURIAL: April 7 1924

20 UNDERTAKER: Frank A. Fink — ADDRESS: 915 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85631

CERTIFICATE OF DEATH.

44 D 85631

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1 Harvest Road ST., Roland Park WARD)

2-FULL NAME Elias Griswold Thelin

(a) RESIDENCE NO. 1 Harvest Road ST., Roland Park WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion F. Thelin

6 DATE OF BIRTH (month, day, and year) May 6th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	50	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm T Thelin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E. Griswold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant H. C. Thelin — brother

(Address) 1 Harvest Road.

Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1924

17 I HEREBY CERTIFY, That I attended deceased from December, 1923, to April 5, 1924,

that I last saw him alive on April 5, 1924,

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the liver

(duration) — yrs. 4 mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? Yes Date of Jan 2-1924

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) Sydney R Miller, M. D.

, 19 (Address) 400 St Paul St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL April 7 1924

20 UNDERTAKER Henry W Jenkins & Co

ADDRESS Orchard & Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17040

D 85632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D 85632

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (NO. ..... ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Powney

(a) RESIDENCE NO. 1038 Granby ST., ... WARD ..... Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 APR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 17th, 1924, to Apr 4th, 1924, that I last saw him alive on Apr 3rd, 1924, and that death occurred, on the date stated above, at 6 00 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Hypertension - Myocardial insufficiency - Chronic nephritis - Uremic toxidosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Am Jacobson, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent — DATE OF BURIAL April 19 24

20 UNDERTAKER Wendell Bryce — ADDRESS 3781 L

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85633

CERTIFICATE OF DEATH.

37 D 85633

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Davis

(a) Residence No. 13 Arch st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1888

7-AGE.	If LESS than 1 day,
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Georgia

PARENTS.

10-NAME OF FATHER. Pranues Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Georgia

12-MAIDEN NAME OF MOTHER, Lottie Ancrum

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). South Carolina

14- (Informant) Hospital Records

(Address) M.T.H.

APR 7 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 14 1924 to Apr. 3 1924

that I last saw him alive on Apr. 3 1924

and that death occurred, on the date stated above, at 8.15 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L.A. Lally M. D

4-4-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Yammassee S.C. DATE OF BURIAL. April 8 - 1924

20-UNDERTAKER. J. L. Burriss & Son ADDRESS 108 W. Monty

Boat to wash-then Coast-line to Yammassee S.C.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Blks.

101 N. Kenwood Ave

D 85634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85634

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 101 S. Chester St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman B. Voelker

(a) Residence No. 101 S. Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Susanna Voelker

6-DATE OF BIRTH (month, day and year) June 19, 1863

7-AGE. 60 yrs. 9 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Henry Smith

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Edward Voelker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Susanna Voelker

(Address) 101 S. Chester St.

15- APR 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 18 19 24 to April 4 19 24

that I last saw h. wife alive on April 4 19 24

and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rydanek M. D.

April 7 24 (Address) 801 N. Kenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Olivet Cem	4/8/24 19....
20-UNDERTAKER.	ADDRESS
H. Deusler & Sons	110 East N

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Grimath)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85635

CERTIFICATE OF DEATH.

X 118-002 D 85635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Grimath

(a) RESIDENCE NO. Carney, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Grimath

6 DATE OF BIRTH (month, day, and year) Nov 9-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John J Grimath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George W. Grimath

(Address) Carney Md.

15 APR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1 1924 to April 4 1924

that I last saw him alive on April 4 1924

and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Intestinal Repill
Shock

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

Arteriosclerosis & Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Carney, Md

Did an operation precede death? No Date of 3/1/24 4/3/24

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B. Dyberry, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 9 1924
20 UNDERTAKER	ADDRESS
H. Gander & Sons	1710 Flat St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85636

D 85636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 W Hamburg ST., 23 WARD)

2-FULL NAME Raymond Ford Carpenter

(a) RESIDENCE NO. 1720 W. Hamburg ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/29/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Alex. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Martha Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Alex. Carpenter
(Address) 1720 W Hamburg St

Filed APR 7 - 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/1924

17 I HEREBY CERTIFY, That I attended deceased from 4/3/1924 to 4/5/1924, that I last saw him alive on 4/5/1924, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Teething

(duration) yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. Thomas Bowley M. D.

4/5/1924 (Address) 908 Druid Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: April 7 1924

20 UNDERTAKER: Edward Bryson — ADDRESS: 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85637

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 Kelly Ave Mt Washington 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Johnson

(a) RESIDENCE No. 25 Kelly ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lettie Hamel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Matilda Johnson

(Address) 25 Kelly Ave

Filed APR 7 - 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1924, to Apr. 4, 1924.

that I last saw him alive on Apr. 4, 1924,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis - Chronic Bright's

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis -

(Signed) E. H. Bolen, M. D.

(Address) Mt Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	4/7 1924
20 UNDERTAKER	ADDRESS
Samuel Wamsley	W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19. H. P. Co. 1000 Blks.

D 85638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85638

CERTIFICATE OF DEATH.

14 161-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1439 Penna- ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Elijah Burrell

(a) RESIDENCE. No. 1439 Pkma ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or eslablishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Sam Burrell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Sam Burrell
(Address) 1439 Penna ave

15 [illegible] Registrar

APR 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to April 5, 1924

that I last saw her alive on April 5, 1924,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thos J Woolridge, M. D.

4-5. 1924 (Address) 703 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frost Arabian cemetery	3/7 1924
20 UNDERTAKER	ADDRESS
Mrs James H. Dennis	1803 Reisterstown

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85639

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2659 Edmondson Ave ST., 70 WARD)

2-FULL NAME Ella Catherine Muthert

(a) RESIDENCE No. 2659 Edmondson Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 30 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	56	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER August Muthert

11 BIRTHPLACE OF FATHER (city or town) Osnabrück
(State or country) Baltimore.

12 MAIDEN NAME OF MOTHER Eliza La Porte

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Elizabeth Klaus.
(Address) 2659 Edmondson Ave.

15 APR 7 - 1924 W. A. Hild Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 - 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20 -, 1924, to April 5, 1924, that I last saw her alive on April 4 -, 1924, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) — yrs. — mos 16 ds.

CONTRIBUTORY (Secondary) Arteria - Sclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs.

(Signed) Chester Riland, ..., M. D.

4-5-, 1924 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL April 7 192X

20 UNDERTAKER W M Rountree — ADDRESS 2238 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85640

CERTIFICATE OF DEATH.

11 3 ✓ D 85640

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1044 N. Mount ST., 16 WARD)

2-FULL NAME Dorothy Gray

(a) RESIDENCE NO. 1044 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Arretta Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hobson Virginia

14 Informant: James Gray (Address) 1044 N. Mount

15 APR 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1924 to April 5, 1924.

that I last saw her alive on April 4, 1924.

and that death occurred, on the date stated above, at 1408 m.

The CAUSE OF DEATH* was as follows:

Rachitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute gastro-enteritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John C. D. Campbell M. D.

19 (Address) 1402 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL 4/7/24

20 UNDERTAKER: P. W. Chase & Son — ADDRESS 1400 Mount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85641 ✓ 129 D 85641

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 N. Schroeder ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A Flood

(a) RESIDENCE NO. 637 N. Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Saml S. Flood

6 DATE OF BIRTH (month, day, and year) July 20/49

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) don't know

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) don't know

14 Informant Edwin D Agnew Jr (Address) 637 N. Schroeder

15 APR 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 26, 1924, to apr 5, 1924, that I last saw her alive on apr 4, 1924, and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

annual (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) W. E. Knight, M. D.

apr 5, 1924 (Address) 1002 N. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL April 7 1924

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85642

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N. Fulton ST. 16 WARD)

2-FULL NAME Mrs. Mary Braly Cost

(a) RESIDENCE NO. 921 N. Fulton ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norman Bruce Cost

6 DATE OF BIRTH (month, day, and year) May 2 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown, Md.

PARENTS

10 NAME OF FATHER Herbert Braly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md.

12 MAIDEN NAME OF MOTHER Mary L. Swartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md.

14 Informant Mrs. Cost
(Address) 921 N. Fulton Ave

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1924, to Apr. 6, 1924, that I last saw her alive on Apr. 6, 1924, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Acute Yellow atrophy of Liver

(duration) yrs. mos 2 / ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lab.

(Signed) Homer C. Todd M. D.

4/7, 1924 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemt — DATE OF BURIAL Apl 7 1924

20 UNDERTAKER J. Ditterline & Son — ADDRESS 1723 W. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85643

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 85643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (St., Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Andrew Knell

(a) RESIDENCE No. 2519 Lurretta Av St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Knell

6 DATE OF BIRTH (month, day, and year): Sept 11 1847

7 AGE: Years 77 Months 5 Days ..... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Street Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer): City 040

(c) Name of employer: Bd

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John A. Knell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mary A. Hufford 2519 Lurretta Av

15 Filed APR 1 - 1924 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1924, to April 5, 1924, that I last saw living alive on April 5, 1924, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Psychosis with Cerebral Arteriosclerosis

Unkn. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Termin. Bronchopneum.

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clynical & Lab.

(Signed) H. Fredowitz M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Apr 8 1924

20 UNDERTAKER: William Cook

ADDRESS: 502 Eastern Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85644

CERTIFICATE OF DEATH.

100001

D 85644

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice V. Welch

(a) Residence No. 2133 W. Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. About 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James L. Welch

11-BIRTHPLACE OF FATHER (city or town). Easton, Penn.
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Amelia J. Campbell

13-BIRTHPLACE OF MOTHER (city or town). Baltimore
(State or Country), Maryland

14- (Informant) Harry T. Welch

(Address) 310 West Belvedere Ave.

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

APR 7 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/5/24

17- I HEREBY CERTIFY, That I attended deceased from April 1 1924 to April 5 1924

that I last saw her alive on April 5 1924

and that death occurred, on the date stated above, at 9-30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Varicose ulcer left leg

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. J. Fulton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Apr. 8, 1924
20-UNDERTAKER.	ADDRESS.
Wm. Cook	602 E. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17-D 85645

HEALTH DEPARTMENT—CITY OF BALTIMORE D 85645

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Thomas Griffin

(a) RESIDENCE NO. 150 N Kenyon St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Carrie Fires

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 7 - 1924 ROBERT P. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1924, to April 5, 1924, that I last saw him alive on April 5, 1924, and that death occurred, on the date stated above, at 11:15 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (left lung)

(duration) yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) Pericarditis with effusion

(duration) yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) H. H. Wiech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Cnuses, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Apr 8 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85646
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 Keyser St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C. Miller

(a) Residence No. 1603 Keyser St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Miller

6-DATE OF BIRTH (month, day and year) July 9/1852

7-AGE. 72 yrs. 7 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laboring

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) German

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Dora Hartstein

(Address) 2575 W. Baltimore St.

15- APR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

Miller 1506 N. Broadway

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 4/24

17- I HEREBY CERTIFY, That I attended deceased from March 16, 1924 to April 4th, 1924 that I last saw him alive on 4-1-4, 1924 and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

1 Myocardial Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	April 7, 1924
20-UNDERTAKER.	ADDRESS
William Cabe	502 E. Fort Ave

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85647

D 85647.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 the. 16- & 4 the Ave ST., 26 WARD)

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sylvia Plumhoff

(a) RESIDENCE No 35 the. 36. & 4 the ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 min ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
	✓			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) City
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry G. Plumhoff

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Tania Zidiman

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Henry G. Plumhoff
(Address) 35 the 36 - 142 Ave

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia - Accd.

(duration) 1 yrs. mos. 10 min ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 12 hrs ds.

(Signed) G. Edwin Blades, M. D.
(Coroner)

4/7/24. 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL H. Matthews — DATE OF BURIAL Apr. 7 1924

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 85648

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2565 Frederick ave ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Littleton Wessels

(a) RESIDENCE NO. 2565 Frederick ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Doran

6 DATE OF BIRTH (month, day, and year) June 11-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) D 5th

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Littleton Burris Wessels

11 BIRTHPLACE OF FATHER (city or town) Accomac Co (State or country) Virginia

12 MAIDEN NAME OF MOTHER Helen Armstrong

13 BIRTHPLACE OF MOTHER (city or town) New Orleans (State or country) Louisiana

14 Informant Sister. (Address) 3702 Mrs William Ballard Clifton Ave

APR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1924, to April 3, 1924, that I last saw h living on April 3, 1924, and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

(Address) 2680 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lawdon Park. DATE OF BURIAL April 7th, 24

20 UNDERTAKER J H Wilhide ADDRESS 1531 Lombard

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 85649

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 843 Hamilton Ter. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sara Aileen Butler

(a) Residence No. 843 Hamilton Terrace St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. Life ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) March 12 1924

7-AGE. ..... yrs. ..... mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of Industry, business, or establishment in which employed (or employer) ✓ ✓
(c) Name of employer ✓

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, H. L. Butler

11-BIRTHPLACE OF FATHER (city or town) Getchelville Pa (State or Country),

12-MAIDEN NAME OF MOTHER, Emily Hayes Hyde

13-BIRTHPLACE OF MOTHER (city or town) Delta Pa (State or Country).

14-(Informant) H. L. Butler

(Address) Cardiff Md

15. APR 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 6 - 1924

17- I HEREBY CERTIFY, That I attended deceased from March 17 1924 to April 6 - 1924, that I last saw the deceased alive on April 5 1924, and that death occurred, on the date stated above, at 4½ a. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert R. Krauter, M. D.

Apr 6, 1924 (Address) 7117 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Delta Pa	Apr 7 1924
20-UNDERTAKER.	ADDRESS
Wm Pickens Sons	York Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85650

CERTIFICATE OF DEATH.

#6 D 85650

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Martin Boteler

(a) RESIDENCE NO. 1814 Edmondson ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Emanuel P Boteler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Rehmer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Father

(Address) 814 Edmondson Ave. City

Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1924, to April 6, 1924,

that I last saw her alive on April 6, 1924

and that death occurred, on the date stated above, at 2 03 A. m.

The CAUSE OF DEATH* was as follows:

Malignant Tumor Type in-definite apparently Carcinoma-Generalized carcinomatosis of abdominal organs. - apparently primary in R. ovary.

(duration) yrs. 6 mos d

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 26, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A B. Price, M. D.

, 19 (Address) U. M. Hospt. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr 8 1924
20 UNDERTAKER Wm J Rickards Sons	ADDRESS North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85651

113 D 85651

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3714 Falls Road St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Clarence Gibson Jr

(a) Residence No. 3714 Falls Road Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 20 1924

7-AGE, ... yrs. 2 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER Clarence Gibson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER Rebecca Baker

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) Clarence Gibson

(Address) 3714 Falls Road

15- Filed APR 7 - 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apl 6 1924

17- I HEREBY CERTIFY, That I attended deceased from April 4th, 1924, to April 6th, 1924,

that I last saw him alive on April 5th, 1924,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Had an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 2 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Hanfords	Apl 7 1924

20-UNDERTAKER CHEROWETH & SON, ADDRESS 3617 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85652 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 D 85652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1061 W Lexington St. 18 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lewis

(Residence in Baltimore: No. 1061 W Lexington St., 10 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, unknown ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
30 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Deck Hand
(b) General nature of industry, business, or establishment in which employed (or employer) S.S. Louisa 0/4

9-BIRTHPLACE, (State or Country). unknown

PARENTS.

10-NAME OF FATHER, Lewis

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country) unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Scarbrough

(Address) 1061 W Lexington

15- APR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 4 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. 1 Da ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

..... (Duration) ..... yrs. ..... mos. 20 ds.

(Signed) James H. Reuben M. D. (Coroner.)

Dated April 4 1924 (Address) 701 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	April 7 1924

20-UNDERTAKER, Brown Freeland & Schroder

ADDRESS 114 N

Spec.—8-24-14—M. & T.—2000 Bks.

D 85653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 Baker St. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Selma Alma Williams

(Residence in Baltimore: No. 548 Baker St.; yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 6, 1923 (Month) (Day) (Year)

7-AGE, yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Home Child

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas Williams

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Selma A. Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Williams

(Address) 548 Baker St

15-

Filed ..... 191.....

APR 7 1924

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3/27 1924, to 4/6 - 1924, that I saw h.. alive on 4/6 - 1924, and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Ac. Bronchitis about 10 days

Ac. Congestion of Lungs ½ day

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exposure & Cold

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. L. Lantter M. D.

4/7, 1924 (Address) 716 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, April 7, 1924

20-UNDERTAKER George I. G. Cohn ADDRESS 1735 Pres. Hilkins

N.B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85654 D

CERTIFICATE OF DEATH.

33 D 85654

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Chambers

(a) Residence No. 656 Pitcher St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Carroll Chambers

6-DATE OF BIRTH (month, day and year) 1887

7-AGE. 37 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS.

10-NAME OF FATHER, Alfred Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Sylvia Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), N. Y

14- (Informant) Municipal Hospital

(Address)

15- Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-4-24

17- I HEREBY CERTIFY, That I attended deceased from 3-29, 1924 to 4-4, 1924

that I last saw h[illegible] alive on 4-3, 1924

and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Peritoneum

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of?

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A Davis M. D.

4-4, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	4-7, 1924
20-UNDERTAKER. George I. A. Tilson	ADDRESS. 1735 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

85655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 85655

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1343 Herkimer ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman M. Yanke

(a) RESIDENCE No. 1343 Herkimer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 3, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	7	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asm. Hammer. Piston Ring Co

(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett Hayward Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Yanke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Domeike

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Michael Yanke

(Address) 1343 Herkimer St.

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18—1924, to Apr. 6— 1924,

that I last saw h— alive on Apr 6— 1924

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Labor Prolonged

(duration) — yrs. — mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of X

Was there an autopsy? Yes

What test confirmed diagnosis? Physicians Impression

(Signed) A. Kerkeley M. D.

4/6, 1924 (Address) 1340 N. Charles.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	Apr. 9, 1924
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John W. Teufel & Son	801 W. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 85656

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Edgehurst & Gordon Road St.) 27 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elise C. Pfanuschmidt

(Residence in Baltimore: No. Edgehurst & Gordon Road St.) 3 yrs. mos. ds.)

4/4 D 85656

REGISTERED No. C

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: May 31 (Month), 1848 (Year)

7-AGE: 75 yrs. 10 mos. 6 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: George F. Vogeler

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Sophie H. Bauer

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Smith

(Address) Edgehurst & Gordon Rd

15

APR 7 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 6th (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5th, 1924, to, April 5th 1924,

that I saw h.. alive on April 5th, 1924,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... yrs. 1 mos. ..... ds

Contributory (SECONDARY) Anasarca

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed), Gilman Thom M. D.

April 6th, 1924 (Address) 133 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 3 yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted. ?

If not at place of death?

Former or usual residence 130 N. Carey St.

19-PLACE OF BURIAL OR REMOVAL: London Park

DATE OF BURIAL: Apr. 8 1924

20-UNDERTAKER: Mc.Mus. J.W. Teufelson

ADDRESS: 801 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85657

CERTIFICATE OF DEATH.

101-801 ✓ D 85657

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Balt Gen Hospital

CITY OF BALTIMORE: (No. 1213 Light ST., 24 WARD)

2-FULL NAME Charles Schley

(a) RESIDENCE NO. 1418 Hull ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 11/15/74

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ None

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Robert Schley

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Mackiewicz

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Schley (Address) 1418 Hull

15 Filed APR 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to April 6, 1924, that I last saw him alive on April 6, 1924, and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) T. A. Cothran, M. D.

, 19 (Address) 1629 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C. A. Co.	4/9/1924
20 UNDERTAKER	ADDRESS
Margaret S. Flynn	142 Light St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85658

CERTIFICATE OF DEATH.

+150 85658

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD 10)

2-FULL NAME Ruth Provance

(a) RESIDENCE No. Point Marion, Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 4, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Pa.
(State or country)

PARENTS

10 NAME OF FATHER John W. Provance

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Bymer

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant John W. Provance
(Address) Pt Marion Pa

15 Filed ....., 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

APR 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1924, to Apr. 5, 1924, that I last saw her alive on Apr. 5, 1924, and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

Surgical Shock - Acidosis
(post-operative)

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary)
Staphylococcus (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Apr 4 1924

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H B Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Port Marion Pa Apr 7 1924

20 UNDERTAKER — ADDRESS
John O Mitchell 1214 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85659

100-001 ✓

D 85659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1419 W. Saratoga ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Florence Carroll

(a) RESIDENCE NO. 1419 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Sinclair S. Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Emily White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pikesville Md

14 Informant: William L. Carroll

(Address): 1419 W. Saratoga St.

15 Date received: APR 7 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to April 5, 1924, that I last saw h.. alive on April 4, 1924, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A. Evans M. D.

19 (Address) 101 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: April 7 1924

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85660

CERTIFICATE OF DEATH.

D 85660

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S Washington St.: 7 WARD)

2-FULL NAME Katherine Weber

(a) RESIDENCE. No. 618 S Washington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
X	1		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Stanislaus Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Frances Kralofsk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr Stanislaus Weber
(Address) 618 S Washington St

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-6, 1924, to 4-6, 1924, that I last saw h alive on 4-6, 1924, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) J. Hurd Bufford M. D.

4-7, 1924 (Address) 800 N Butl Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	April 7 1924

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

199 D 85661

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth Eibley

(Residence in Baltimore: No. 2004 Booth St (yrs. 18) mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word)
Female	white	Married

6-DATE OF BIRTH, Mar (Month) 2 (Day) 1890 (Year)

7-AGE, 34 yrs. 1 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Hungaria

PARENTS.

10-NAME OF FATHER. Matthew Lux

11-BIRTHPLACE OF FATHER. (State or Country), Hungaria

12-MAIDEN NAME OF MOTHER. Elizabeth Seger

13-BIRTHPLACE OF MOTHER, (State or Country), Hungaria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Frank Eibley

(Address)..... 2004 Booth St

15- APR 7 - 1924 Burial Permit

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 3 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis following abortion self induced

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) septicaemia

(Duration) ....yrs. ....mos. 6 ds.

(Signed) James M Hunter M. D.
(Coroner.)

April 4 1924 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents)
At place of death....yrs....mos. 6 ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 2004 Booth St

19-PLACE OF BURIAL OR REMOVAL, Greenmount DATE OF BURIAL April 7th 1924

20-UNDERTAKER, J. B. Hepfinger ADDRESS 2256 Fleet Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85662 ✓ D 85662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 N. Caury ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E Taylor

(a) RESIDENCE NO. 604 N. Caury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 25 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lorenzo Dow Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Angeline Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant (Signature and address) Dr Hugh L Bowyer 1 E Lexington St Mt Washington

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to April 6, 1924.

that I last saw h alive on April 5, 1924,

and that death occurred, on the date stated above, at 8.30a m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Uraemia, Acute Bright's

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

, 19 (Address) 101 N. Caury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Apr 8 1924

20 UNDERTAKER A B Marshall ADDRESS 3539 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85663 ✓

D 85663

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 26 WARD)

2-FULL NAME Lillian Nemiller

(a) RESIDENCE NO. 416 N. 14 ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2nd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Nemiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Baumer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Hospital Records.

(Address)

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 19 24

17

I HEREBY CERTIFY, That I attended deceased from Mch 30, 19 24, to Apr. 4, 19 24,

that I last saw h[illegible] alive on Apr 4, 19 24,

and that death occurred, on the date stated above, at 1 50 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis-

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mch 30/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. J. Flyler M. D.

(Address) University Hospital

, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	April 7 1924
20 UNDERTAKER Lilly-Zeiler	ADDRESS 4033 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 85664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hosp. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Walters (Walter.

(a) RESIDENCE NO. 1221 N Gay Street ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	54	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U.S. Coast Guard Service

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Government 886

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hosp' records (Address)

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17

I HEREBY CERTIFY, That I attended deceased from July 31 1923 to apl 6 1924, that I last saw him alive on apl 6 1924, and that death occurred, on the date stated above, at 3.03 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with paralysis.

Arteriosclerosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) M. A. Foster M. D.

1110 19 Address U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	April 9 1924
20 UNDERTAKER Lilly & Giles	ADDRESS 403½ W Fayette,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 85665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S. Clinton St ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann White

(a) RESIDENCE NO. 708 S. Clinton ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 - 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Dougherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Ann O'Connor
(Address) 708 S Clinton St.

15 APR 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 1924, to 4/6, 1924, that I last saw her alive on 4/4, 1924 and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McGarrell, M. D.

(Address) 633 S. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL April 8 1924

20 UNDERTAKER Lilly & Zeller ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09 D 85666

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Apt ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bella Drey

(a) RESIDENCE NO. Marlborough Apts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 4/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Abraham Drey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dvic Lower

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs E Drey
(Address) Marlborough

15 Filed APR 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Remark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to April 6, 1924,
that I last saw her alive on April 6, 1924,
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I. Frederick Leitz M. D.

4-7, 1924 (Address) 2040 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Sinai DATE OF BURIAL April 8 1924

20 UNDERTAKER David Sondheim ADDRESS 1180 Park Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85668 — 85667 — 74-081 — D 85668

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Walson St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R. Smith

(a) Residence No. 909 Walson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Smith

6-DATE OF BIRTH (month, day and year) July 9 1857

7-AGE.	If LESS than 1 day.
67 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer): 886
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Louis Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Polly Knott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va.

14-
(Informant) Sarah Smith
(Address) 909 Walson St

15- APR 7 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 5 1924

17- I HEREBY CERTIFY, That I attended deceased from March 29, 1924 to Apr 5, 1924
that I last saw h.. alive on Apr 4, 1924
and that death occurred, on the date stated above, at 6:45 a.m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

Interstate (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Edward Fisher M. D.

Apr 7, 1924 (Address) 1622 Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Antrim Cemetery	Apr 8, 1924
20-UNDERTAKER, Wm. R. A. Elliott	ADDRESS 1720 E. Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85668

8566 8

CERTIFICATE OF DEATH.

D 85668

1-PLACE OF DEATH

REGISTERED NO. 15 10[illegible]

CITY OF BALTIMORE: (No. 1820 Clifton Av. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice B. Bailey

(a) RESIDENCE. NO. 1820 Clifton Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 8 mos. 8 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Bailey

6 DATE OF BIRTH (month, day, and year) July 28, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor W. R. R.

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer W. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. E. Bailey,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Anna E. Wakeland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County Md.

14 Informant Geo. E. Bailey, (Address) 1812 Riggs Ave.

15 Filed ..... 19.. Robert F. Harrison Registrar

PR 7 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 5, 1924, that I last saw him alive on April 5, 1924, and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) John D. Quinn, M. D.

4/6, 1924 (Address) 1507 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	April 9 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 85669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 85669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Andrew Anderson

(a) Residence No. 701 S. Bond st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1879

7-AGE. 45 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Seaman

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Norway

PARENTS.

10-NAME OF FATHER. Andrew Anderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Sweden

12-MAIDEN NAME OF MOTHER. Andrielle Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Norway

14- (Informant) Hospital Records

(Address) M.T.H. UNIV

15- Filed APR 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 28 19 24 to April 3 19 24

that I last saw him alive on April 3 19 24,

and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO. Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally, M. D

4-3- , 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. APR 7 1924 19....

20-UNDERTAKER. Commissioner Health. ADDRESS

Per. Wm. E. Woodall

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

April 6th 85670

Body Patrick Gillon

M. W. 45 yrs. from Pier 9 Locust Point

Drowned.

Rembrandt

7th Turned over to Denny &

715 Light St

Cor.—1-12-23—M&T—100 Bks.

D 85670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X182 D 85670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier No. 9 Locust Point ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Gillen.

(a) RESIDENCE NO. 21 Watson St. Central Falls, R. I. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boatsman mate. 086
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Santa Cecelia
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Frank Gillen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Frank Gillen. R. I.
(Address) 21 Watson St Central Falls

15 Filed APR 7 - 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

Missing February 8, 1924. Body found

16 DATE OF DEATH (month, day, and year) April 5, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning. Probably accidental fall overboard from S/S Santa Cecelia.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Albert Reinhardt M. D.
(Coroner.)

April 7, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Central Falls - R.I. Via Providence R.R. DATE OF BURIAL April 7 1924

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

If NOT buried, cremated or removed within 24 hours, a permit should be obtained from the Registrar before the body is removed. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will be required by law to report deaths promptly. Certificates may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Smelter)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85671

CERTIFICATE OF DEATH.

D 85671

161-61

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Dennison ST., 21 WARD)

Curley Smelter

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mamie

(a) RESIDENCE NO. 1115 Dennison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/3/24

7 AGE: Years | Months: 6 months | Days: 2 days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed APR 7 - 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/3/, 1924, to 4/4/, 1924, that I last saw h[illegible] alive on 4/3/24, 19 , and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Reed Dunn, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Rohrer, State Board

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health,

APR 5 - 192

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85672

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1003 N. Charles St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Valentine

(a) Residence No. 1003 N. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Valentine

6-DATE OF BIRTH (month, day and year)

7-AGE. 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Mt. Savage
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Loftus

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary McCormick

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Ireland

11- (Informant) Dr. Francis J. Valentine
(Address) 1003 N. Charles St.

15- 4-1924 Robert P. Harrison, 192
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 5-24

17- I HEREBY CERTIFY, That I attended deceased from Sept — 1923 to Apr. 5 1924
that I last saw him alive on Apr. 5 1924,
and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Malignancy of pleura (left)

(Duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) C.C. Myocardial insufficiency 24 hrs.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carroll Lockard M. D

Apr 6 1924 (Address) 42 Preston St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	4/8 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

R 7

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85673

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1807 Park Avenue St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William George Robertson

(a) Residence No. 1807 Park Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Brent Digges

6-DATE OF BIRTH (month, day and year) Feb. 15, 1844

7-AGE. 80 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Montgomery Co. Maryland

PARENTS.

10-NAME OF FATHER: William G. Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Montgomery Co. Maryland

12-MAIDEN NAME OF MOTHER: Victorine Key Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Maryland

14- (Informant): Miss Victorine Key Roberts

(Address): 1807 Park Avenue

15- Filed APR 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 5-24

17- I HEREBY CERTIFY, That I attended deceased from Abt April, 1922 to Apr 5, 1924 that I last saw h[illegible] alive on April 4, 1924 and that death occurred, on the date stated above, at 6, a m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No,

What test confirmed diagnosis? Physical Examination

(Signed) Irvin Eberly M. D

Apr 7, 1924 (Address) 710 W Fayette Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	4/8 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Clara R. Davis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85674

101-001 D 85674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Wyndale & Payson Aves ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clara R. Davis

(a) RESIDENCE NO. 19 W. Biddle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. N. Davis

6 DATE OF BIRTH (month, day, and year) Dec. 10 - 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis C. Hoover

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Maria V. Lowery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mrs. Chas. R. Smoot

(Address) 601 Dumbarton Rd.

15 APR 7 - 1924 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17

I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to April 7, 1924, that I last saw her alive on April 7, 1924, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. test

(Signed) [illegible] M. D.

4/7/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Apr 9 1924

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS 4 North & Penna Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85675

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Crighton

(a) RESIDENCE NO. Gulfport Miss. ST., WARD Gulfport Miss.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Creighton

6 DATE OF BIRTH (month, day, and year) 1868. Dec 8

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Miss

PARENTS

10 NAME OF FATHER Wm. Edward

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER A. J. White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Miss

14 JOHNS HOPKINS HOSPITAL. Informant

(Address)

15 APR 7 1924 Filed, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 8. 1924. to April 7. 1924.

that I last saw he alive on April 7. 1924.

and that death occurred, on the date stated above, at 8.10 a.m.

The CAUSE OF DEATH* was as follows:

General peritonitis

Paralytic ileus

Cardiac failure.

(duration) — yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Ovary.

(duration) — yrs 6 mos. 2 ds.

18 Where was disease contracted if not at place of death? Gulfport Miss.

Did an operation precede death? Yes Date of Apr 3, 24

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) R W Linde, M. D.

, 19 (Address) Johns Hopkins Hospital Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gulfport Miss.	Apr 7. 1924
20 UNDERTAKER	ADDRESS
Chas Mitchell	120 Virginia Ave.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(London)

D 85676 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. D 85676

1-PLACE OF DEATH University Hospital

REGISTERED NO. 179

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Veronica Jerdon

(a) RESIDENCE NO. 625 Lombard ST., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1911.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Jerdon

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Hawkins

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant University Hospital Records
(Address) Lombard & Greene St.

15 Filed 4-1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to April 4, 1924,

that I last saw h[illegible] alive on April 4, 1924,

and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Second degree burns over 3/4 of body. Many large areas 3rd degree burns.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis + Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Wallace Walker, M. D.

, 19 (Address) Lombard & Greene Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4-7-1924
20 UNDERTAKER Daniel Fenton	ADDRESS 96 Carey

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRI

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 85677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital No 31 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pinkney Johnson

(a) Residence No. Unknown St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Don't know How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: Louis Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Harriett Matthews

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

11- (Informant): Patient

(Address): .....

18- Filed ..... 19.. Robert P. Harrison, Registrar.

APR 7 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-5-1924

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to April 6 1924, that I last saw h[illegible]ative on April 6, 1924, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

2 Years.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Pulmonary Hemorrhage

(Duration) 0 yrs. 0 mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray - Sputum

(Signed) L. A. Lally, M. D

4-7-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-8, 1924
20-UNDERTAKER	**ADDRESS**
Dan'l Eastern	City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Lindner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85678

CERTIFICATE OF DEATH.

100-001 D 85678

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Millington Ave ST., 20 WARD)

2-FULL NAME Edward James Lindner

(a) RESIDENCE No. 513 Millington Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	28	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Andnor

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Rose Rosenburger

13 BIRTHPLACE OF MOTHER (city or town) Paris
(State or country)

14 Informant Rose Andnor
(Address) 513 Millington Ave

15 Filed APR 7 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to April 6, 1924,
that I last saw him alive on April 5, 1924,
and that death occurred, on the date stated above, at 12 10 m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Endocarditis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Norbert X C Kelch, M. D.

4/7, 1924 (Address) 251 Aulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 4-8 1924

20 UNDERTAKER Robt. T. Turner

ADDRESS 1442 N. Bethel

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85679

D 85679

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Lchester Ave WARD)

2-FULL NAME Eda Wilmot

(a) RESIDENCE. No. 324 Lchester Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Wilmot

6 DATE OF BIRTH (month, day, and year) Sept. 12 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Redbank N.J.

PARENTS

10 NAME OF FATHER W. R. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Christine Stange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn N.Y.

11 Informant Deceased (Address)

15 Robert P. Harrison, 19

Burial Permit Clerk. Registrar

PR 7 -1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/26 1924, to 4/6 1924, that I last saw her alive on 4/6 1924, and that death occurred, on the date stated above, at 12 10a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Heart Examination

(Signed) E. J. Carroll M. D.

19 (Address) 1510 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/8/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85680

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 W. North ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Octavia Schultz

(a) RESIDENCE NO. 1932 W. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? 60 yrs. 7 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE~~ of Kendall H. Schultz

6 DATE OF BIRTH (month, day, and year) Sept. 5-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stephen C. Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Janet Nicol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Stephen C. Little

(Address) 2420 E Balto st

15 APR 7 - 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 1924

17 I HEREBY CERTIFY, That I attended deceased from November, 1923, to April 6, 1924, that I last saw h w alive on April 5, 1924, and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) — yrs. 6 (?) mos — ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 9. 1923

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) W. A. Boyce man, M. D.

, 19 (Address) 2136 W. north ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Apr 8 1924
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1744 W. North ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85681 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 215 Harris St., 19 Ward) 101-001

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Keen

(Residence in Baltimore: No. 215 Harris St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Dec (Month) 30 (Day) 1923 (Year)

7-AGE. 0 yrs. 3 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore City

PARENTS.

10-NAME OF FATHER. Harry Keen

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore City

12-MAIDEN NAME OF MOTHER. Eula Milburn

13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eula Keen

(Address) 715 Harris St

15- Filed APR 7 1924 Robert P. Harrison, 192..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 4 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) John M. Fowler M. D. (Coroner.)

April 4 1924 (Address) 700 Chase

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western	April 8th 1924
20-UNDERTAKER,	ADDRESS
John J. Fields	1200 W Lombard

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 E 27 st. ST., 12 WARD)

REGISTERED NO. 94

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Feliciano Altieri

(a) RESIDENCE NO. 437-E-27 st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Domenica Altieri

6 DATE OF BIRTH (month, day, and year): April 25 1889

7 AGE: Years 35 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer): 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Joseph Altieri

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Filomia Ricci

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Mrs. Domenica Altieri

(Address) 437 E. 27 st.

15 APR 7 - 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1924

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1924, to April 5, 1924,

that I last saw him alive on April 5, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septic lymphangitis

(from self scratching)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) acute nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. Testa, M. D.

, 19 (Address) 210 Pearl st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: April 8 1924

20 UNDERTAKER: George F Rutter

ADDRESS: 1735 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 85683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85683

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2661 Wilkins ave St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Irma M. Kennedy

(Residence in Baltimore: No. 2661 Wilkens ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

6-DATE OF BIRTH. ..... Jan (Month) ..... 3 (Day) ..... 1891 (Year)

7-AGE. ..... 32 yrs. 10 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), Salt Lake City

PARENTS.

10-NAME OF FATHER, Wm J. Ogden

11-BIRTHPLACE OF FATHER, (State or Country), Salt Lake City

12-MAIDEN NAME OF MOTHER, Lena Alexander

13-BIRTHPLACE OF MOTHER, (State or Country), Salt Lake City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert E. Kennedy

(Address) 2661 Wilkens ave

15-

Filed APR 7 1924 Robert P. Marriott, 192.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 5 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull & neck by fall from back 2nd Story Porch & Concrete walk

Accident (Duration)..... yrs. Instant mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Jeremiah M. Fenton M. D. (Coroner.)

April 7 1924 (Address) 700 E. Chase St.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. Apr. 8 1924

20-UNDERTAKER. Joseph L. B. Cook ADDRESS 1003 N. Bethel St.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Paul Whelan Jr.

(Residence in Baltimore: No. 1029 W. Lombard Street St.; yrs., life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. October 13, 1922
(Month) (Day) (Year)

7-AGE. 1 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. William Paul Whelan

11-BIRTHPLACE OF FATHER, (State or Country). Chicago, Illinois

12-MAIDEN NAME OF MOTHER. Alma C. Brehm

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Paul Whelan

(Address) 1029 W. Lombard Street

15- Robert P. Harrison,

Filed APR 7 - 1924 192.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 6, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix - Localized Peritonitis
(Autopsy at Hopkins Hospital)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. Sutton Cotton M. D.
(Coroner.)

4-7 192.... (Address) 505 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. Apr 8" 192..

20-UNDERTAKER. Jacob B Cook ADDRESS 1003 N. Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-28

D 85685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 Patapsco ST. 23 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Michael Skelley.

(a) RESIDENCE. No. 1214 Patapsco ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John M. Skelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Elkton Md

12 MAIDEN NAME OF MOTHER Theresa Partenotaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John M. Skelly 1214 Patapsco St.

15 APR 7 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4. 5. 24 19

17 I HEREBY CERTIFY, That I attended deceased from 3. 29. 24 19 , to 4. 5. 24 19 ,

that I last saw him alive on 4. 5. 24 19 ,

and that death occurred, on the date stated above, at 6.16 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. of Chest.

(Signed) J. Edward Morris M. D.

4. 6. 1924 (Address) 107 E. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery a.a.	April 8 1924
20 UNDERTAKER	ADDRESS
Margaret E. Flynn	1422 Light St

IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified: Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21—M&T—1500 Bks.

D 85686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37

D 85686

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 N Mount ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Kyler

(a) RESIDENCE NO. 536 N Mt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Cold

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John N Kyler

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: 55 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Dove

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Matilda Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Calvert Co

14 Informant: Blanch Kyler (Address) 536 N. Mount St

15 APR 8 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 4 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-2- , 1924 , to 4-4- , 1924 ,

that I last saw her alive on 4-4- , 1924 ,

and that death occurred, on the date stated above, at 130 a. m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs 1 day

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W Bissell, M. D.

, 19 (Address) Walthrop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Apr 8 1924

20 UNDERTAKER: John N. Frazier — ADDRESS 142 Uswell

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1933 46 1877

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85687

CERTIFICATE OF DEATH.

D 85687

1-PLACE OF DEATH

REGISTERED NO. 15 47

CITY OF BALTIMORE. (No. 377 N Carey St. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willie A Jackson

(a) RESIDENCE No. 377 N Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ephraim Jackson

6 DATE OF BIRTH (month, day, and year): Feb 1877

7 AGE — Years: 46 — Months: 6 — Days: — If LESS than 1 day, ... hrs. or ..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Lawrence Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Ephraim Jackson

(Address): 377 N Carey St

15 APR 8 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 - 6 1924

17

I HEREBY CERTIFY, That I attended deceased from 3-29-, 1924, to 4 - 5, 1924,

that I last saw her alive on 4 - 5 - 1924,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer Breast

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James H Walters, M. D.

, 19 (Address) 1311 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: April 8th 1924

20 UNDERTAKER: Hammel & Wright — ADDRESS: 1264 W Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85688

CERTIFICATE OF DEATH.

100-001

D 85688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital ST., 6 WARD)

2-FULL NAME John H. Frostburg

(a) RESIDENCE NO. 4 N. Potomac ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Frostburg

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) 057

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant Mary Jones
(Address) 4 N. Potomac St.

15 Filed APR 8 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to April 6, 1924.

that I last saw him alive on April 5, 1924,

and that death occurred, on the date stated above, at 2.55 a. m.

The CAUSE OF DEATH* was as follows:

Psychosis with Arteriosclerosis

Unkn. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic & Lab.

(Signed) J. H. Smith M. D.

4/6/1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Clare Cemetery DATE OF BURIAL April 8, 1924.

20 UNDERTAKER John A. Moran ADDRESS 3000 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85689

D 85689

CERTIFICATE OF DEATH.

40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1511 N. Regester ST., 8 WARD)

2-FULL NAME Margaret L Stoecker

(a) RESIDENCE No. 1511 N. Regester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? 36 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Bartholomy A. Stoecker

6 DATE OF BIRTH (month, day, and year) Aug. 10 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Buettner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Bartholomy Stoecker

(Address) 1511 N. Regester

15 APR 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1924, to Apr 6, 1924.

that I last saw her alive on Apr 6, 1924.

and that death occurred, on the date stated above, at 12 15 A. m.

The CAUSE OF DEATH* was as follows:

Herpes Zoidens

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Encephalitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. A. Schultz, M. D.

, 19 (Address) 1107 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 9 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 85690

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Harford Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Hesbian Hussey

(a) RESIDENCE No. 1705 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1 Grown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Geraghty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Winifred Mullaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Hesbian Hussey

(Address) 1705 Harford Ave

15 Filed APR 8 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/13, 1923, to 4/7, 1924,

that I last saw her alive on 4/6, 1924

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Unknown (duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/19/23

Was there an autopsy? Complications of Coma

What test confirmed diagnosis? Urinalysis

(Signed) Dr Leonard Wolff, M. D.

4/7, 1924 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 10 1924
20 UNDERTAKER	**ADDRESS**
Henry Hoerle Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

85691

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 85691

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Clare Hospital ST., 15 WARD)

2-FULL NAME Jacob Immerman

(a) RESIDENCE NO. 3409 Park Heights Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retail

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Hyman Immerman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Katz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jacob Immerman
(Address) 3409 Park Heights Ave

15 Filed APR 8 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-1924

17 I HEREBY CERTIFY, That I attended deceased from 3-5-'24, 19..., to 4-7-'24, 19...

that I last saw him alive on 4-7-24, 19...

and that death occurred, on the date stated above, at 12 40 p m.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) ... yrs. ... mos ? ... ds.

CONTRIBUTORY (Secondary) A. appendicitis. (Ruptured ?)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3-7-24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Jno Gladdough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hebron Rosedale — DATE OF BURIAL 4-8-1924

20 UNDERTAKER Jacob Lewis, 1431 E. Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 85692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N Hilton ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Latum

(a) RESIDENCE NO. 432 N Hilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Latum

6 DATE OF BIRTH (month, day, and year) April 7/1841

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	83	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Daniel Latum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary N. Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John Pratt 432 N Hilton

15 Filed APR 8 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1924 to April 6, 1924

that I last saw him alive on April 5, 1924

and that death occurred, on the date stated above, at 12-20 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

April 6, 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

UNDERTAKER ROBERT BROOKS & SON FUNERAL DIRECTORS & EMBALMERS S. E. CORNER CALHOUN & HOLLINS STREETS

DATE OF BURIAL 4/8 1924

ADDRESS Calhoun Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85693

CERTIFICATE OF DEATH.

90

D 85693

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brown

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE.	If LESS than 1 day.
70 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9-BIRTHPLACE (city or town) Maryland (State or Country),

PARENTS.

10-NAME OF FATHER, Thomas Hawkins

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Sarah E. Isaac

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Municipal Hospital Record

(Address)

15- ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

APR 8 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-6-24

17- I HEREBY CERTIFY, That I attended deceased from 3-24, 1924 to 4-6, 1924

that I last saw her alive on 4-6 1924

and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

Myocardial Insufficiency

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude F. Drane, M. D.

4-6 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Auburn Cemetery	April 8th 1924
20-UNDERTAKER.	ADDRESS
Jas. M. Johnson	309 Druid Hill Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85694

X 100-001 ✓

CERTIFICATE OF DEATH.

D 85694

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 Edgevale Rd St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Bonsal Hoge

(a) Residence No. 207 Edgevale Rd St., 27 Ward Phila. Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 9 ds. How long in U. S., if of foreign birth? 70 yrs. 6 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Norton Hoge

6-DATE OF BIRTH (month, day and year) Oct-2-1853

7-AGE, 70 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Office

(c) Name of employer Provident Life & Trust Co

9-BIRTHPLACE (city or town). Belmont Co.
(State or Country), Ohio

PARENTS.

10-NAME OF FATHER, John C. Hoge

11-BIRTHPLACE OF FATHER (city or town). Belmont Co.
(State or Country), Ohio

12-MAIDEN NAME OF MOTHER Rebecca Bonsal

13-BIRTHPLACE OF MOTHER (city or town) Belmont Co.
(State or Country), Ohio

14- (Informant) Mrs. Harry E. Karr daughter

(Address) 207 Edgevale Rd. City.

15- APR 8 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 6th 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to Apr. 6, 1924, that I last saw h. alive on April 6 1924, and that death occurred, on the date stated above, at 8-25 a.m.

The CAUSE OF DEATH* was as follows:

Gauta
Bronchitis Pneumonia

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) M. J. Porter, M. D.

4/6, 1924 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Ridge Cemetery — DATE OF BURIAL, April 8, 1924

20-UNDERTAKER STEPHEN G. MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

IF THIS IS A PERMANENT RECO
should be carefully supplied. AGE should be stated E
in plain terms, so that it may be properly classified.
instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85695

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hopkins Apts St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Mileon Dobbs

(a) Residence No. Hopkins Apts St., 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 40 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lavinia Birchett Dobbs

6-DATE OF BIRTH (month, day and year) April-6-1870

7-AGE 53 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Lime-Cement-

(c) Name of employer Hudson Lime & Cement Co.

9-BIRTHPLACE (city or town) (State or Country), Wales England

PARENTS.

10-NAME OF FATHER, John Dobbs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Rotterdam U.S.A.

12-MAIDEN NAME OF MOTHER, Cannot Ascertain

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Wales England

14-INFORMANT (Informant) Mrs Lavinia B. Dobbs-(wife)

(Address) Hopkins Apts., City

15-FILED APR 8 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 4 1924

I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1924, to April 4, 1924, that I last saw him alive on April 4, 1924, and that death occurred, on the date stated above, at 5-55 P. m.

The CAUSE OF DEATH* was as follows:

Central Embolism due Cardiac Thrombosis, Chronic Endocarditis with loss of Compensation. Myocarditis

(Duration) 1 + yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. 1 mos. 15 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. Gibson Porter, M. D.

4/5/, 1924 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery — DATE OF BURIAL, April-7, 1924

20-UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

U. S. WRITE PLAINLY, WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1354 D 85696

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital (Street) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel K. George

(a) RESIDENCE NO. 115 W. North Ave ST., 12 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? 57 yrs. 10 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Ella Colvert Carter

6 DATE OF BIRTH (month, day, and year) May-12-1836

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired-farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER Samuel K. George

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Vermont

14 Informant (Son) Mr Carlin George
(Address) Universal Apts - City

15 Filed APR 8 - 1924 ROBERT F. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8- 1924

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to April 8, 1924, that I last saw him alive on April 7, 1924, and that death occurred, on the date stated above, at 12 2/3 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis, prostatitis cystitis epididymitis.

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Leptocaumia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of 3-24-24

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Raymond I. Johnston, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Cemy - Elliott City Md — DATE OF BURIAL: April 10 1924

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. NORTH AVE.

Spec.—1-10-21 M&T 1500 Blks.

D 85697 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 D 85697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 S. Stockton ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard A. Gross

(a) RESIDENCE NO. 9 S. Stockton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr - 83

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Rohland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Gross
(Address) 9 S Stockton

15 APR 8 - 1924 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1924, to April 6, 1924, that I last saw him alive on April 5, 1924, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms.

(Signed) J. L. Sammons, M. D.

(Address) 904 E. Clarke St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Gen	Apr 9 1924
20 UNDERTAKER	ADDRESS
Sam'l W. Chase Sons	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85698

CERTIFICATE OF DEATH.

×90 D 85698

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard Street ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Crockett

(a) RESIDENCE NO. Crisfield, Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexia Crockett (nee Parks)

6 DATE OF BIRTH (month, day, and year) April 15-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailboat Captain

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Major Crockett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Alexia Crockett

(Address) 6 Somerset Ave Crisfield Md

15 APR 8 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1924, to Apr. 7, 1924.

that I last saw him alive on Apr. 7, 1924,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Coronary Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical finding.

(Signed) James F. White, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crisfield, Md	April 9, 1924
20 UNDERTAKER Harry S. Pitzke	ADDRESS 153 W. Lombard

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85699

D 85699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wm Sanders

(a) Residence No. Emmitsburg, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 24 yrs mos ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Emmitsburg, Md

PARENTS.

10-NAME OF FATHER. Geo. Sanders.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Emma Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

11- (Informant) Geo. Sanders

(Address) Emmitsburg Md

15- APR 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 8 1924

17- "I HEREBY CERTIFY, That I attended deceased from April 4 1924 to April 8 1924

that I last saw him alive on April 5, 1924

and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gangrenous Perforated Meckels Diverticulates

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? Yes Date of 4/7/24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H O Harper M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Emmittsburg Md

DATE OF BURIAL. April 8 1924

20-UNDERTAKER. Chas. T. Block 742

ADDRESS W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85700

D 85700

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1602 N. Broadway

REGISTERED NO. 8 74 D 85700

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1602 N. Broadway ST.; 8 WARD)

2-FULL NAME William E Harden

(a) RESIDENCE. NO. 1602 N Broadway ST., 8 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret V. Harden

6 DATE OF BIRTH (month, day, and year) April 21 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-binder

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Government

(c) Name of employer Printing department

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard E. Harden

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda Redmond

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md.

14 Informant Margaret V Harden (wife) (Address) 1602 ~~ROBERT R. KRAUTER,~~ Broadway

15 Filed APR 8 - 1924 19 Burial Permit Clerk, ~~Registrar~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1923, to April 7, 1924, that I last saw him alive on April 7, 1924, and that death occurred, on the date stated above, at 1.25 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration One yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual clinical tests

(Signed) C. H. Macdonald, M. D.

April 7, 1924 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 9th 1924
20 UNDERTAKER	ADDRESS
Geo E Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85701

CERTIFICATE OF DEATH.

90 D 85701

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 W. Lanvale ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Bolton

(a) RESIDENCE. NO. 306 W. Lanvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm. H. Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Olivia Fossett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Frank Fisher
(Address) 1607 Eutaw Place

15 Registered ROBERT R. KRAUTER Apr 8 - 1924
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch. 27, 1924 to Apr. 6, 1924.
that I last saw her alive on Apr. 6, 1924.
and that death occurred, on the date stated above, at 10.20 P. m.
The CAUSE OF DEATH* was as follows:

Cordiac Dilatation

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) Over-Exertion, Likely

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no. Clinical Symptoms

What test confirmed diagnosis?

(Signed) Wm. M. Baumbaker, M. D.

19 (Address) 209 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	Apr 9 1924

20 UNDERTAKER ADDRESS
John O. Mitchell 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will please note that it may be properly classified. Exact statements are required. Read instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85702
Registered No.

PLACE OF DEATH
(If death occurred in hospital or institution give its NAME instead of street and number.)

OF BALTIMORE (No. 243 S. Pearl St., 4 Ward)

FULL NAME Frank H Rinando

(a) Residence No. 243 Pearl St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-Single, Married, Widowed, Divorced (Write the word.): Married
If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sarah Feliitta Rinando
6-DATE OF BIRTH (month, day and year): Unknown
7-AGE: 70 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Fruit Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Italy

PARENTS:
10-NAME OF FATHER: Joseph Rinando
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12-MAIDEN NAME OF MOTHER: Emma Giglio
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14-(Informant): Sarah F Rinando
(Address): 243 Pearl St

15-Filed APR 8 1924, 19... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 2

17-I HEREBY CERTIFY, That I attended deceased from March 30 1924 to April 6 1924
that I last saw h... alive on Apr 6 1924
and that death occurred, on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH* was as follows:
gangrene from decubitus

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): arthritis deformans
(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. Lester M.D.
19 (Address) 240 Pearl St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral
DATE OF BURIAL: April 9 1924
20-UNDERTAKER: John O Mitch...

Spec—12-23-21—E.P.R.S.—400 Eks.

D 85703 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 85703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No 2640 E Oliver St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest E Lohr

(a) Residence No. 2640 E Oliver St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single,~~ Married, ~~Widowed, or Divorced~~ (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Amelia Lohr

6-DATE OF BIRTH (month, day and year): March 29, 1859

7-AGE: 65 yrs. — mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter 050
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Frederick E Lohr

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dora Ruter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-Informant: Amelia Lohr
(Address) 2640 E Oliver

15-Filed APR 8 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr 7/1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 24, 19 24 to Apr 7, 19 24, that I last saw h.... alive on Apr 6 19 24 and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. G. Keller M. D.

Apr 9, 19 24 (Address) 130 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Apr 10, 1924

20-UNDERTAKER: John Ulrich — ADDRESS: 2008 Gilmore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 806 N. Rose St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph A. Koenig

(a) Residence No. 806 N. Rose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed,~~ ~~or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa A. Schreiber

6-DATE OF BIRTH (month, day and year) Dec 12, 1869

7-AGE. 55 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Baker

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

003

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Koenig

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret Hutzler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Rose Koenig
(Address) 806 N. Rose St.

15- Filed ..... 192.. ROBERT R. KRAUTER Registrar.

APR 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 5 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1923 to April 5 1924

that I last saw him alive on April 5 1924

and that death occurred, on the date stated above, at 10 00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastrica Pylorus)

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 19 24

Was there an autopsy?

What test confirmed diagnosis? Microscopic Exam

(Signed) Louis A. M. Krause M. D.

, 19 (Address) 2500 E. Eastwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cem	Apr 8 1924
20-UNDERTAKER. John Ulrich	ADDRESS 700 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85705

CERTIFICATE OF DEATH.

11-001

D 85705

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 S. Ellwood Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Harry R. Bremer

(a) Residence No... 613 S Ellwood St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bremer

6-DATE OF BIRTH (month, day and year) Mar 4/1871

7-AGE. 52 yrs. 11 mos. 28 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John R Bremer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Dorothy Ballinger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Mrs Dorothy Bremer

(Address) 104 N Streeper

15- Filed APR 3 - 1924 ROBERT R. KRAUTER Registrar.

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 6/1924

17- I HEREBY CERTIFY, That I attended deceased from April 3 1924 to April 6 1924

that I last saw h.. alive on April 5th 24

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

La Grippe

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F. Ed Bunting M. D.

4-9 1924 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL. Apr 8 1924

20-UNDERTAKER John Meerier

ADDRESS 2008 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85706

CERTIFICATE OF DEATH.

8 X 129

D 85706

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 E. Lanvale St., [illegible] Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Wilkinson

(a) Residence No. 1612 E Lanvale St., ... Ward. Lanvale

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 Weeks ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 9-1861

7-AGE, 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Leather worker

(b) General nature of Industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Wilmington Del

PARENTS.

10-NAME OF FATHER John Wilkinson

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER Ann Mc Cull

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Ella Rosenberger

(Address) 1612 E Lanvale st

15- Filed APR 8 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 6-1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 6, 1924, that I last saw him alive on April 6, 1924, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Dyspnea & edema of lungs

Mitral Insufficiency

Arteriosclerosis

(Duration) .....yrs. 1 mos. .....ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) .....yrs. 1 mos. .....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) H. D. Cannaday, M. D.

4-7, 19 (Address) 1701 N Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Wilmington Del. DATE OF BURIAL, Apl 9, 1924

20-UNDERTAKER Robt L Kramer Sr ADDRESS 1 N Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85707

CERTIFICATE OF DEATH.

47 D 85707

1-PLACE OF DEATH

City of BALTIMORE: (No. 2040 E Lanvale St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katherine Thorwarth

(a) Residence No. 2040 E Lanvale St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 25 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) married

5a-If married, ~~widowed, or divorced~~, HUSBAND of (or) WIFE of Joseph Thorwarth

6-DATE OF BIRTH (month, day and year) Sept 24-1874

7-AGE, 50 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Wilhelm Zuech

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Selosa

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Joseph Thorwarth

(Address) 2040 E Lanvale st

15- APR 8 - 1924 Burial Permit Clerk, ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 6-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 8th/ ....., 19 24, to April 6th ....., 19 24, that I last saw h[er] alive on April 6th ....., 19 24, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Objective & subjective symptoms

(Signed) David Miller, M. D.

, 19 (Address) 1506 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Wood Lawn Cemetery — DATE OF BURIAL, April 9, 1924

20-UNDERTAKER, Robt J Turner Sons — ADDRESS 1462 E Broadway

Spec. 6-9-10—11-2, Gen. 1000 Bks.

D 85708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 85708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2220 Elsinor Av ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hogendorp

(a) RESIDENCE. NO. 2220 Elsinor Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
~~WIFE of~~ HUSBAND of Mary Grace Hogendorp

6 DATE OF BIRTH (month, day, and year) Oct. 6/1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Supt.
(b) General nature of industry, business, or establishment in which employed (or employer) Joel Gutman's
(c) Name of employer Department Store

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elias Hogendorp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Caroline Kuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Caroline Hogendorp
(Address) 2220 Elsinor Av

15 Filed APR 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1921, to April 6, 1924, that I last saw him alive on April 6, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Angina pectoris

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris (3rd attack)
(duration) 2 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Prima typical attacks

(Signed) Chas C Judd, M. D.

, 19 (Address) 170 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	April 9 1924

20 UNDERTAKER	ADDRESS
Chas. E. Franck	807 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(New)

D 85709

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

23 D 85709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Southern Av ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifton Lew.

(a) RESIDENCE NO. 1 Southern Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. Harmless mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25/1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) United R.R. Co

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Wm G. Lew

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sally Greenwood

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Geo. H. Lew
(Address) 1 Southern Ave.

15 APR 8 - 1924 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to April 8, 1924, that I last saw h alive on April 8, 1924, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. A. Blumenthal M. D.

19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 10 1924
20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave.

Cor.—1-12-23—M&T—100 Bks.

D 85710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-801 ✓

100 D 85710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Low ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milford Johnson

(a) RESIDENCE NO. 1118 Low ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Feb. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Marshall

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant John Johnson
(Address) 1118 Low St

15 Filed 192 Robert P. Harrison, Registrar

APR 8 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Cullen, M. D.
(Coroner.)

Apr 8/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL Apr. 9 192 4

20 UNDERTAKER Thos J. Locks ADDRESS 1302 Jeffer

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 85711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 Harford ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Amos

(a) RESIDENCE NO. 1829 Harford ave ST., ... WARD .....

(Usual place of abode)

Leagth of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Amos

6 DATE OF BIRTH (month, day, and year): Aug 4 1849

7 AGE — Years: 74 — Months: 8 — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah A. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): John J. Amos 1829 Harford ave

APR 8 - 1924 Filed ..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1924, to Apr 7, 1924, that I last saw h[illegible] alive on April 7, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John J Blake, M. D.

Apr 8, 1924 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 4/10 1924

20 UNDERTAKER: Fiske & Perkins

ADDRESS 1739 Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85712

CERTIFICATE OF DEATH.

74-92 ✓

D 85712

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Patapsco Ave Brooklyn WARD 25)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Isabel Geis

(a) RESIDENCE No. 508 Patapsco Ave. Brooklyn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Julia~~ Harry Geis

6 DATE OF BIRTH (month, day, and year): Jan 6 1870

7 AGE — Years: 54 — Months: 3 — Days: 1 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Wilkerson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Childs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Harry Geis

(Address): 508 Patapsco Ave

15 FEB 8 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1924, to April 7, 1924.

that I last saw Mr alive on April 6, 1924,

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis resulting in Hemiplegia

(duration) — yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) - - - - - - - - -

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of - - - - - -

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Harry Weibel M. D.

4/8. 1924 (Address) 1224 Hanover Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: Apl 9 1924

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85713

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ann E Thames ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Brown

(a) RESIDENCE NO " " ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	b	Not Known

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
about 25				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

087

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant
(Address)

15 Filed ..., 192 Robert P. Harrison, Registrar

APR 8 1924

Deputy Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquisy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hospital

(duration) yrs. mos. ds.

(Signed) J. C. Blades, M. D. (Coroner.)

3/31/24, 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	192
20 UNDERTAKER Commissioner of Health.	ADDRESS

Per Wm. E. WOODALL

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85714 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 85714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward) 66X

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Williams or Gerber

(a) Residence No. Lexington, Virginia St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) ?

7-AGE.	If LESS than 1 day.
40 ? yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ? 087
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) ? (State or Country).

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country).

14- (Informant) Municipal Hospital
(Address) UNIVERSITY OF MARYLAND.

15- Filed APR 8 - 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-4-24

17- I HEREBY CERTIFY, That I attended deceased from 3-31, 1924 to 4-4, 1924 that I last saw him alive on 4-4, 1924 and that death occurred, on the date stated above, at 1 ....m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism
Chronic Alcoholism
(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Sat
(Signed) Claude 9. Dean M. D.
4-8, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ..., 19....
20-UNDERTAKER, Commissioner Health,	ADDRESS APR 8 - 1924

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85715

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 626 N. Calvert St. St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John G. Gilloohy

(a) Residence No. 626 N. Calvert St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May ? 1871

7-AGE. 52 yrs. 10 mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Express Man

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer. Self

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Gilooly

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Anna ?

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Mary Gilooly

(Address) 626 N. Calvert St

15- Filed APR 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 27, 1924, to Apr 6, 1924, that I last saw h[illegible] alive on Apr 6, 1924, and that death occurred, on the date stated above, at 3.50 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Do not know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? 626 N Calvert St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edward C. Talbot M. D.

4/6, 1924 (Address) 16 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. W[illegible] Cathedral — DATE OF BURIAL. Apr 9, 1924

20-UNDERTAKER. Wm Cook — ADDRESS E Hamilton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Baby Spedalieri)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85716

CERTIFICATE OF DEATH.

D 85716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 W. Lee St.; 22 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME newborn of Francesco Spedalieri & Carmela Izzara

(Residence in Baltimore: No. 137 W. Lee St. St.; ....yrs....mos....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, April (Month) 7 (Day), 1924 (Year)

7-AGE, ...yrs....mos....da.

If LESS than 1 day, ...hrs. or 10 min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Francesco Spedalieri

11-BIRTHPLACE OF FATHER (State or Country) Italy

12-MAIDEN NAME OF MOTHER Carmela Izzara

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francesco Spedalieri

(Address) 137 W. Lee St

15- Filed APR 8 1924, 191.... Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 7 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191..., to April 7 1924, that I saw him alive on April 7 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

difficult extraction
breech presentation
(Duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary)
(Duration) ....yrs....mos....da.

(Signed) Chas. J. Fiske M. D.

....., 191... (Address) 210 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....da. In the State ....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem	April 7, 1924
20-UNDERTAKER	**ADDRESS**
John J. Curran & Son	701 Hollins St

NOTE—THIS IS A PERMANENT RECORD—WRITE PLAINLY, WITH UNFADING INK—THE UNDERTAKER should be careful. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85717

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85717

1-PLACE OF DEATH

City of BALTIMORE: (No. Forest Av — Morrell Park 27 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Catherine A Clifford

(a) Residence No.... Forest Av — Morrell Pk St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 18. 1923

7-AGE, ...yrs. 3 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, Wm F. Clifford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Mary Roth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt

14- (Informant) William F. Clifford

(Address) N Morrell Park

15- Filed APR 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 8-24

17- I HEREBY CERTIFY, That I attended deceased from April 2, 1924 to April 8, 1924

that I last saw h[illegible] alive on April 8, 1924

and that death occurred, on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W Jones M. D.

(Address) 222 Edgewood Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cem — DATE OF BURIAL, 4-10-1924

20-UNDERTAKER, Geo. J. Smith — ADDRESS 1532 Hollins St

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 85718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85718

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2127 E. Lombard St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Alexander Barber

(a) Residence No.... 2127 E. Lombard St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie S. Barber

6-DATE OF BIRTH (month, day and year) Nov. 26, 1856

7-AGE. 67 yrs. 4 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)..... Court

(c) Name of employer.....

009

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER Michael Barber

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER Catherine Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Annie S. Barber
(Address) 2127 E. Lombard St.

15- Filed APR 8 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 7th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1st 1923 to April 7th 1924 that I last saw him alive on April 5th 1924 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. 2 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert S. Kirk M. D
4/7, 1924 (Address) 3126 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem.	April 9th 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander Sons	1710 Fleet St.

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

See Letter on file May 3rd 1924

D 85719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85719

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2203 E. Eager ST., 7 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine Strubin

(a) RESIDENCE NO. 2203 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Strubin

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work AT home
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country)

14
Informant Albert Strubin
(Address) 2203 E. Eager St

15
Filed ....., 192 Robert P. Harris...
Registrar
PR8 - 1924 Burial Permit clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Right sided thoracic hemorrhage
Cause unknown, probably anuerism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cocen, M. D.
(Coroner.)

Apr 7/24. 192 (Address 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 11 192 4

20 UNDERTAKER Grant Erickson — ADDRESS 1906 Eutaw

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

A D 85720 (10675) — 74 D 85720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 1 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Billings

(a) RESIDENCE NO. Johns Hopkins Hospital
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	—	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 69

(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins Hospital

(c) Name of employer Miss Crawford

9 BIRTHPLACE (city or town) Loegland
(State or country) (Leicestershire) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER — ?

13 BIRTHPLACE OF MOTHER (city or town) — ?
(State or country)

14 JOHNS HOPKINS HOSPITAL
Informant
(Address)

15 Robert P. Harrison, M.D. 19
Registrar

FEB 8 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 25, 1924, to Apr. 6 1924, 19 ....,

that I last saw h alive on Apr. 6 1924,

and that death occurred, on the date stated above, at 5:35 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 0 yrs. 0 mos 13 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nov

(Signed) Laurence A Rothe, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 9 1924
20 UNDERTAKER	ADDRESS
Joseph Ahrens	421 B Way

B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr Fitzgerald 1600 E Fourth ao

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85721

CERTIFICATE OF DEATH.

101-09 D 85721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 E. Madison ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME C Keturah Redmond

(a) RESIDENCE NO. 2515 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	widow.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Redmond.

6 DATE OF BIRTH (month, day, and year) June 20-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Chas H. Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash D.C.

12 MAIDEN NAME OF MOTHER Mary J Dillon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Beulah Redmond

(Address) 2515 E. Madison

15 Filed 19 Robert P. Ayris, Registrar

Burial Permit Clerk.

PR8 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1923, to April 7, 1924, that I last saw h.. alive on April 6, 1924 and that death occurred, on the date stated above, at 5 45 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pleurisy (duration) yrs. 2 mos 10 ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Allan G Fitzgerald, M. D.

4/7/. 1924 (Address) 1613 E Fourth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL Apr 10 1924

20 UNDERTAKER Merrbook & Son ADDRESS E North.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OBSTETRICAL TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85722

CERTIFICATE OF DEATH.

34 D 85722

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John White

(a) Residence No. 407 Garrison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E.

6-DATE OF BIRTH (month, day and year) Dec 2 1866

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9-BIRTHPLACE (city or town) (State or Country), Somerset County Maryland

PARENTS.

10-NAME OF FATHER, Wesley White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Leah Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Margaret E White

(Address) 1723 Hollins Ave.

15- Filed 1924 Robert P. Harrison, 19.. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/7/24

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to April 7, 19 24.

that I last saw him alive on April 7, 19 24.

and that death occurred, on the date stated above, at 8-45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Larynx - Dorsal & Lumbar (Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence - X-Ray

(Signed) Wm. J. Fulton M. D.

. 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Island Md. DATE OF BURIAL, 4-10, 1924

20-UNDERTAKER, Wm Cook ADDRESS 502 E Fort Ave.

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OR8

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85723

CERTIFICATE OF DEATH.

90 D 85723

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3806 Woodbine Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Philip Mason

(a) Residence No. 3806 Woodbine Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gustine Mason

6-DATE OF BIRTH (month, day and year) Jan 8th, 1842

7-AGE: 82 yrs. 2 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer:

9-BIRTHPLACE (city or town) Gloucester Co. (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Milton W. Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Elizabeth Royston

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11 (Informant) Mrs Gustine Mason

(Address) 3806 Woodbine Ave

15- Filed ..... 192.... Robert P. Harrison, Registrar.

PR8 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 7th, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 10, 1924 to Apr. 7, 1924

that I last saw h... alive on 4-17- 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Senility Arterio Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert Lovell M. D.

, 19 (Address) 3705 Liberty Hgts. Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	April 10th, 1924
20-UNDERTAKER, Bertram B. Rose	ADDRESS 1723 W. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85724 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85724

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig Podowski

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1848

7-AGE. 76 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ..... Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Austria

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Austria

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Austria

14- (Informant) Municipal Hospital Records
(Address) .....

15- Filed APR 8 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-4-24

17- I HEREBY CERTIFY, That I attended deceased from 4-3, 19.24 to 4-4, 19.24

that I last saw him alive on 4-4, 19.24

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Myocarditis
Myocardial degeneration

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Pease, M. D.
4-4, 19.24 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 4-9, 19.24
20-UNDERTAKER. L. J. Tabler & Sons	ADDRESS 1318 Light St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85725

CERTIFICATE OF DEATH.

D 85725/1923 28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 N. Stockton St.: 16 38 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE. No. 1140 Stockton St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Johnson

6 DATE OF BIRTH (month, day, and year) April 9, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	28	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer Mrs. Allen Poyntd Park Apts.

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER George Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Hattie Mowbray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md.

14 Informant Harry Johnson (Address) 1140 Stockton St.

15 Filed APR 9 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1924, to April 8, 1924, that I last saw h.....alive on April 5, 1924, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Erysepelas

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Uremia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician etc.

(Signed) William F. Wright M. D.

(Address) 1209 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md.	April 10 1924
20 UNDERTAKER	ADDRESS
Thomas Eldridge	864 W. Cary St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 85726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85726

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital 19 161-08 Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kraft.

(a) Residence No. 192 N. Stricker St. Balto. Md Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F.	W.	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) .....

7-AGE. Infant ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... —

(b) General nature of industry, business, or estaldishment in which employed (or employer) ..... —

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Harry Kraft.

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, Jennie L. McCoy

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or Country),

14- Harry Kraft. (Informant)

(Address) 192 N. Stricker St

APR 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 7- 1924 to Apr. 7- 1924

that I last saw h.. alive on Apr. 7- 1924,

and that death occurred, on the date stated above, at 7:50 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Transverse presentation

complicated (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Dudley P. Bowe M. D

, 19 (Address) 904- N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	4/9, 1924
20-UNDERTAKER,	ADDRESS
Henry W. Means & Son	805 N. Eutaw St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

170826 Urol.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85727

CERTIFICATE OF DEATH.

X 131 ✓

D 85727

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Freeland

(a) RESIDENCE NO. Chester, Md. St., Kent Island Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Freeland

6 DATE OF BIRTH (month, day, and year) ? ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0140

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to April 7, 1924, that I last saw him alive on April 7, 1924, and that death occurred, on the date stated above, at 1308 m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis - Uremia.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy Prostate.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Chester Md

Did an operation precede death? No. Date of 4-7-24

Was there an autopsy? Yes.

What test confirmed diagnosis? Exam of Kidneys

(Signed) Robert Wm Kerr, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kent Island	April 9 1924
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85728

CERTIFICATE OF DEATH.

D 85728

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1616 Harley ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Fischer

(a) Residence No. 1616 Harley ave St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Fischer

6-DATE OF BIRTH (month, day and year) May 16th 1851

7-AGE. 72 yrs. 10 mos. 9 ds.

If LESS than 1 day, ...hrs. or....mth.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... U. S.
(State or Country), Balt Md

PARENTS.

10-NAME OF FATHER, George Engle

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14- (Informant) George Fischer

(Address) 1616 Harley ave

APR 9 - 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 7th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to April 7 1924

that I last saw her alive on April 7 1924

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma + Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis + Physical Exam

(Signed) Albert Abramberg M. D.

5/8/ 1924 (Address) 1027 E. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. April 11th 1924

20-UNDERTAKER. Lilly + Zeiler ADDRESS 1438 Mosher St.

N. B.—WHITE PAPER, WITH UNFADING INK—THIS CERTIFICATE IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85729

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

D 85729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 209 S. Washington St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabetta Trucks

(a) Residence No. 209 S. Washington St., 2 Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of the late Henry Trucks.

6-DATE OF BIRTH (month, day and year) Jan 24 1848

7-AGE.	If LESS than 1 day,
76 yrs. 2 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Balto. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Frederick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbara Beck.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Mary Siegmund

(Address) 209 S. Washington St.

15-

APR 9 - 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923 to April 5, 1924

that I last saw h[illegible] alive on April 5, 1924

and that death occurred, on the date stated above, at 11.50 a/m.

The CAUSE OF DEATH* was as follows:

Chronic tubercular heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? physical

(Signed) Geo. Keller M.D.

4/7, 1924 (Address) 1937 Gough St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer Cemetery	April 9th, 1924
20-UNDERTAKER.	**ADDRESS**
Lilly & Zeiler	400 S. Wolfe St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1655 4 P.M. D 85730 100-001 D 85730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Thawley

(a) RESIDENCE NO. 2423 E. Hoffman St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ ~~(or) WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) April 7 - 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter 070
(b) General nature of industry, business, or establishment in which employed (or employer) Porter at Hotel Belvedere
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 JOHNS HOPKINS HOSPITAL
Informant .....
(Address)

15 Filed APR 9 - 1924, 19 ... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 1924, to April 6, 1924, that I last saw him alive on April 6, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Bacterial Endocarditis

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy.

(Signed) Warfield M. Firor M. D.
6, 19 24 (Address) J H Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL April 10 1924

20 UNDERTAKER Lilly + Zeiler — ADDRESS 4038 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85731

CERTIFICATE OF DEATH.

90 ✓ 6

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew Aged Home St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josef H. Rosenstock

(a) Residence No. 2206 E. Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Rosenstock

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
85 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hebrew 68

(b) General nature of Industry, business, or establishment in which employed (or employer) Teacher

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Simon Rosenstock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 E Baltimore St

15- Filed APR 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4 — 9 — 24

17- I HEREBY CERTIFY, That I attended deceased from March 15, 19 24 to April 9, 19 24

that I last saw him alive on April 1, 19 24

and that death occurred, on the date stated above, at a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Wm. J. Bauer, M. D.

4/9, 19 24 (Address) 210 N. Howard

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	4-9, 19 24
20-UNDERTAKER	**ADDRESS**
Jack Levis 1439	E Balto St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85732 — 118-002 — D 85732

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Koenig

(a) RESIDENCE NO. 5611 Belmont Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Koenig

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73 yrs.	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Stiff (Finn Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rev. E. G. Barger
(Address) Belmont Ave.

15 Filed APR 9 1924 ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction (Duodenal) (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D. (Coroner.)

April 9, 1924 (Address) 28 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 10
20 UNDERTAKER	ADDRESS
Mrs. Mrs J. W. Teufel Son	801 W Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85733

D 85733

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2308 Arunah Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Bethke,

(a) Residence No. 2308 Arunah Ave, St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced
[redacted] of (or) WIFE Charles A.T.Bethke,

6-DATE OF BIRTH (month, day and year) June 21.1862

7-AGE,	If LESS than 1 day.
61 yrs. 8 mos. 18 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)
(State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER August Schollmeyer,

11-BIRTHPLACE OF FATHER (city or town)
(State or Country) Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country) Germany

14-
(Informant) Charles A.T.Bethke,
(Address) 2308 Arunah Ave.

15-
Filed APR 9 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 8.1924

17- I HEREBY CERTIFY, That I attended deceased from 2.27.24., 19....., to 4.8.24., 19.....

that I last saw h.er alive on 4.7.24, 19.....

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

(Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical – microscopic chemical.

(Signed) Phillip B. Fowler M.D.

APR 9 19 1924 (Address) 1432 William St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Western Cem.	APR 10 1924 19....

20-UNDERTAKER, Geo W Settle

ADDRESS 1706 EDMONDSON AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

188 D 85734

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME S. Milton Miles

(a) RESIDENCE No. 406 N Poppleton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara A. Miles,

6 DATE OF BIRTH (month, day, and year) August 10. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer J. F. Wiesner & Co.

066

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Miles,

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Marcella S. Johnson,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant W. Harold Miles

(Address) 406 N. Poppleton St.

15 Filed APR 3 - 1924, 192 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto collision, Shock

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Haemorrhage,

(Duration) yrs. mos. ds.

(Signed) Geo. Edwin Blade, M. D.

(Coroner.)

3/7/24, 192 (Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

DATE OF BURIAL APR 5 - 1924 192

20 UNDERTAKER Geo W. Little

ADDRESS 2700 Pennsylvania Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85735

CERTIFICATE OF DEATH.

1601 D 85735

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1007 Roland Heights Ave WARD)

2-FULL NAME Doris Elaine Williams

(a) RESIDENCE No. 1007 Roland Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John. E. Williams

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth E. Parker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs Elizabeth E. Williams
(Address) 1007. Roland Heights ave

15 Filed APR 9 - 1924 ROBERT R. KRAUTER, Assistant
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1924, to April 8, 1924, that I last saw h[illegible] alive on April 7, 1924, and that death occurred, on the date stated above, at 7. A. m.

The CAUSE OF DEATH* was as follows:

Asphyxiation premature birth - 7 months gestation

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. J. Davis, M. D.

April 8 1924 (Address) 600 W 33 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery Hampden	4/9. 1924
20 UNDERTAKER J. WALTER DAVIS, FUNERAL DIRECTOR J. W. Davis	ADDRESS 3307. Paine. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85736

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 85736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Smith Benson

(a) RESIDENCE No. 1014 Cathedral St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 53 yrs. 8 mos. 3 ds.

Resident

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rodney Benson

6 DATE OF BIRTH (month, day, and year): Aug-5-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Ecleville (State or country) Virginia

PARENTS

10 NAME OF FATHER Peter Bowdoin Smith

11 BIRTHPLACE OF FATHER (city or town) Ecleville (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Cupper

13 BIRTHPLACE OF MOTHER (city or town) Ballentown (State or country) Maryland.

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 9 - 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to April 2, 1924, that I last saw her alive on April 2, 1924, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Purulent bronchitis

(duration) 0 yrs. 0 mos 4 da.

CONTRIBUTORY (Secondary) bronchopneumonia

(duration) 0 yrs. 0 mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [signature], M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery

DATE OF BURIAL: Apr 9 1924

20 UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS: 108 W. NORTH [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85737

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. I29 W. West. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Burley.

(a) RESIDENCE No. I29 W. West. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred I2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 I869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	8	I2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unkown

12 MAIDEN NAME OF MOTHER Kittie Golver.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Martha Brown. I29 W. West. St.

Filed APR 9 - 1924 ROBERT R. KEMP, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6th " 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14th, 1923, to April 6th 1924.

that I last saw her alive on April 5th " 1924

and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Insufficiency of Heart

(duration) — yrs. 11 mos 23 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Heibel M. D.

4/9, 1924 (Address) 1324 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leonard Grank — DATE OF BURIAL: 4/9 24

20 UNDERTAKER: Samuel Hendry — ADDRESS: Seattle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 85738

CERTIFICATE OF DEATH.

D 85738

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 N. Stricker St., 16 WARD)

2-FULL NAME Valley O. Stokes

(a) RESIDENCE NO. 1017 N. Stricker St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Valley V. Stokes

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Estelle M. Wise

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Valley V. Stokes
(Address) 1017 N. Stricker St.

15 Filed APR 9 - 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to the death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

April 7, 1924 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 4/9 1924

20 UNDERTAKER Samuel Hemsley

ADDRESS 2 E. Lexington St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 85739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 101-001

D 85739

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Druid Hill Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Matthews

(a) RESIDENCE. No. 2020 Druid Hill Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Edgar Matthews

6 DATE OF BIRTH (month, day, and year): Dec 2 1876

7 AGE: Years 47 Months 3 Days 13

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Easton Md

PARENTS

10 NAME OF FATHER: Wilson Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edgar Matthews (Address) 2026 McCulloh St

15 Filed APR 9 1924 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 25th 1924 to April 7th 1924

that I last saw h.er alive on April 7th 1924

and that death occurred, on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pleuro Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Lautenbach M. D.

4-8, 1924 (Address) 2215 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Easton Md — DATE OF BURIAL: 4/9 24

20 UNDERTAKER: Samuel H. Greenley — ADDRESS: Middle

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85740

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hardy Commander

(a) RESIDENCE No. 1527 W. Fayette St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Bl	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Singleton

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Jesse Commander

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Annie Lester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Annie Burk (Address) 1547 W Fayette st

15 Filed APR 9 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-1924

17

I HEREBY CERTIFY, That I attended deceased from 3-4-1924, to 4-6-1924,

that I last saw him alive on 4-6-1924,

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Hyper. Prostate

Cystitis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) acute Cardiac failure

prob. Pulm. Embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-28-24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. J Parr, M. D.

(Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 9 1924

20 UNDERTAKER P. J. Frost ADDRESS 1460 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85741

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-901

D 85741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1502 N. Mof St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Pfeifer

(a) Residence No. 1502 N Mof St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of John Pfeifer

6-DATE OF BIRTH (month, day and year) June 11-1866

7-AGE. 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Jos. Herulz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Ereszintia Seigel

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

11- (Informant) John Pfeifer

(Address) 1502 N Mof St

15- Filed APR 9 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 1st 1923 to April 6 1924

That I last saw her alive on April 5 1924

and that death occurred, on the date stated above, at 12 50 A. M.

The CAUSE OF DEATH* was as follows:

Pylonic Stenosis, Ulcer of Stomach

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Asthma

..... (Duration) ..... yrs. 2 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) By J. W. Leary M. D.

4/9. 24 (Address) 4 N Paca

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Emmanuel Cem.	4-9 1924
20-UNDERTAKER,	ADDRESS
Wm Chas A Pohle	22 Arlington Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Conquest)

D 85742 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 5 31 D 85742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 East ST., 5 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Conquest

(a) RESIDENCE NO. 16 East ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Alfred Conquest

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mackenburg Va.

PARENTS

10 NAME OF FATHER Baxter Gary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mackenburg Va

12 MAIDEN NAME OF MOTHER Margret Valentine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mackenburg Va

14 Informant Alfred Conquest

(Address) 16 East Street

APR 9 - 1924

ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924. to April 7, 1924. that I last saw her alive on April 7, 1924, and that death occurred, on the date stated above, at 10.45P m.

The CAUSE OF DEATH* was as follows:

Haemmorhage of Lungs

Tuberculosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 3 mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr S W Kennard M. D.

4-8. 1924 (Address) 708 Encor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	4/10 1924
20 UNDERTAKER	ADDRESS
Jas. Wm. Skinner	1625 E. Lnad st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 85743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85743

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard H. Brooks(C)

(a) RESIDENCE No 1st. & Calvert Sts. Brooklyn. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 19, 1868.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer. 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER Richard Brooks(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Mary Jackson(C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md.

14 Informant William E. Brooks(C)(brother)
(Address) A. A. Co. Md.

15 Filed APR 9 - 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the face & body. Upsetting of an oil lamp.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)
April 9, 192 4 (Address) 1014 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident April 6, 1924. 1st. & Calvert Sts. Brooklyn.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williams Cem. A. A. Co. Md. DATE OF BURIAL Apr 9 1924

20 UNDERTAKER John H. Toadvine ADDRESS 142 Union St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 85744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

100 D 85744

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 W. Barree Street. ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Johnson(C).

(a) RESIDENCE NO 635 W. Barree Street. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) May 25, ~~1922.~~ 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	..	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Johnson(C)

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Bessie Kager(C).

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) A. A. Co. Md

14 Informant Roberta Sutton (C)(aunt)
(Address) 642 Redwood Street.

15 Filed APR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1924 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
Primary.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)
April 9, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gambrels A.A. Co md — DATE OF BURIAL apr 10 1924

20 UNDERTAKER John H Toadvine — ADDRESS 1x2 Uptield St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

147 D 85745

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. ~~5419 Madison~~ ave ST.: [illegible] WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Parker

(a) RESIDENCE. NO. 5419 Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willard Parker

6 DATE OF BIRTH (month, day, and year) Feb 27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James W Macneal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Grace B

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Willard Parker

(Address) 5419 Madison ave

APR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from during last pregnancy, 19..., to ..., 19...,

that I last saw h[illegible] alive on April 7, 1924,

and that death occurred, on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:

Uremic toxemia post-partum eclampsia

10 hrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause of eclampsia unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Le Davis M. D.

, 19 (Address) 827 N. Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL April 9 1924

20 UNDERTAKER W S M Routson

ADDRESS 2238 N Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-22—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85746

CERTIFICATE OF DEATH.

90 D 85746

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3810 Cottage Ave ST., 15 WARD)

2-FULL NAME Philip S. Rosenberg

(a) RESIDENCE NO. 3810 Cottage Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hanis Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Isaacs
(Address) 3810 Cottage Ave

APR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1923, to April 8th, 1924

that I last saw her alive on April 8, 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hypertension & Myocarditis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Schuerel M. D.

4/9, 1924 (Address) 2328 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/9 1924

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Lesardi

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85747

CERTIFICATE OF DEATH.

X 74-001 V

D 85747

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Jr. D Sagrino, Hospital St.; 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lesardi

(Residence in Baltimore: No. Unknown St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M.	White	Unknown

6-DATE OF BIRTH, Sept 14, 1887
(Month) (Day) (Year)

7-AGE, 37 yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)..... No

9-BIRTHPLACE, (State or Country) Porto Rico

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) U.S. Marine Hosp

(Address) Remington Ave

15-

Filed APR 9 - 1924, 191.. ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 8, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquisition (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

April 9 1924. (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery

DATE OF BURIAL, 4/10, 1924

20-UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 85748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X177 D 85748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Smith

(a) RESIDENCE No. 276 Portland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Smith

6 DATE OF BIRTH (month, day, and year) Nov 6 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 640
(c) Name of employer

9 BIRTHPLACE (city or town) Roanoke Va
(State or country)

PARENTS

10 NAME OF FATHER David Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Laura Smith
(Address) Bellona Ave & Belvedere

15 Filed APR 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hg Cl2 Poisoning

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Nephritis.

(duration) yrs. mos. 1 ds.

(Signed) Geo Clinton Black M.D.
(Coroner.)

, 192 (Address) 1433 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 10 1924
20 UNDERTAKER	ADDRESS
Wendell Duffy & Son	[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85749

CERTIFICATE OF DEATH.

D 85749

1—PLACE OF DEATH

CITY OF BALTIMORE: No. Loudon Hastor ST., 6 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2—FULL NAME Mrs Stewart

(a) RESIDENCE No. 1627 Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colloed	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Luber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lula Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Stewart
(Address) 1627 Jefferson

15 Filed APR 8 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Drowning Accd

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

(Signed) Geo Edwin Weber M. D.
(Coroner)

, 192 (Address) 1410 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt [redacted]

DATE OF BURIAL April 9 1924

20 UNDERTAKER R C Gross 1405 M[redacted]

ADDRESS Edmondson

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec--12-23-21—E.B.R.S.—400 Bks.

D 85750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85750

1-PLACE OF DEATH Bay View Hospital 14 38 Registered No.....

City of BALTIMORE: (No..... St., 14 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Austin Lucas.

(a) Residence No. 1923 Brunt St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Blk.

5-Single, Married, Widowed, Married or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of ~~Mary~~ Fannie Lucas

6-DATE OF BIRTH (month, day and year) 1872.

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Labour.

(b) General nature of Industry, business, or establishment in which employed (or employer). 040

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do.

14- (Informant) Bay View Hospital

(Address) Eastern Ave. & ste.

15- APR 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/7/24.

17- I HEREBY CERTIFY, That I attended deceased from July 13, 1923 to Apr. 6, 1924 that I last saw him alive on April 6, 1924 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Paralysis of the Insane

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + autopsy findings

(Signed) H. H. Dorsett M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	4-11 1924
20-UNDERTAKER.	ADDRESS
David Easton	96 Ca ns

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85751 CERTIFICATE OF DEATH. 161-08 D 85751

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2420 Buchanan St. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thornton

(a) RESIDENCE NO. 2420 Buchanan St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
4	4	4	4	6 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Son

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mildred Valley

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Maryland

14 Informant (Address) JOHNS HOPKINS HOSPITAL,

15 APR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 9, 1924, that I last saw him alive on April 9, 1924, and that death occurred, on the date stated above, at 4 5-7 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Physical conditions of Mother (duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Ball M. D.

, 19 (Address) 1906 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL APR 9 - 1924

20 UNDERTAKER — ADDRESS

Commissioner Health.

Per. Wm. S. Rodgers

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Priebe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85752

CERTIFICATE OF DEATH.

131 D 85752

1-PLACE OF DEATH Howard Melvin Priebe REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Priebe

(a) RESIDENCE NO. 528 S. Longwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Rudolph Priebe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant [signature] (Address) 528 S. Longwood St

APR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1924

17

I HEREBY CERTIFY, That I attended deceased from 3/28, 1924, to 4/8, 1924,

that I last saw him alive on 4/8, 1924,

and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Injections arthritis with involvement of sterno-clavicular joint

Severe secondary anaemia.

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of April 2, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Inspection

(Signed) [signature], M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 14, 1924
UNDERTAKER	ADDRESS
F. B. Wellington & Sons	

N. B.—WRITE PLAINLY, WITH INK. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Eks.

D 85753 HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ D 85753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2822 Kennedy ave St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine E. Enright

(a) Residence No. 2822 Kennedy ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write this word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 14 1897

7-AGE. 26 yrs. 9 mos. 25 ds.

If LESS than 1 day hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer). Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Philip Enright

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md

12-MAIDEN NAME OF MOTHER. Mary A. Quinn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Delaware

14- (Informant) Mary Enright

(Address) 2822 Kennedy ave

15- APR 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apl 8-1924

17- I HEREBY CERTIFY, That I attended deceased from 4/8/24, 19.. to 4/8/24, 19.., that I last saw her alive on 4/7/24, 19.., and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H W Sanders M. D

4/8/24 19 (Address) 321 E 25

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	4/12 19 24
20-UNDERTAKER.	ADDRESS
Chas F. Evans & Son	118 W Mt Royal ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Louis H. Baumgartel)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85754

CERTIFICATE OF DEATH.

74-01 ✓ 85754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N Bath St ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis H. Baumgartel

(a) RESIDENCE No 918 N Bath St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Retired

9 BIRTHPLACE (city or town)
(State or country) N. Y.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Henry C. Hitchcock
(Address) 815 E. 22nd

15 Filed APR 9 - 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) about abt 4th- 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to h00 death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

(Signed) W K Georgelas M. D.
(Coroner.)

April 8, 1924 (Address) 117 N Canal St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 9 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Pimlico – 2105 Edna St.

D 85755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85755

CERTIFICATE OF DEATH.

X 101-001

12

1-PLACE OF DEATH

City of BALTIMORE: (No. 2121 Gilford Ave St. ..... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albina Mineath

(a) Residence No. 2121 Gilford Ave St., ... Ward Dryden N. Y.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 6 1839

7-AGE,	If LESS than 1 day.
84 yrs. 5 mos. 24 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), N. Y. State

PARENTS.

10-NAME OF FATHER, John Mineath

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), N. Y.

12-MAIDEN NAME OF MOTHER, Sabrina Sodge

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), N. Y.

14-

(Informant) Elsie M. Arms

(Address) 2121 Gilford Ave

15-

Filed APR 9 - 1924, 192?

Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9 1924

17- I HEREBY CERTIFY, That I attended deceased from April 6, 1924, to April 9, 1924, that I last saw h[illegible] alive on April 8, 1924, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ..... Date of .....

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Jos. H. Pleasants, M. D.

, 19 (Address) 205 N. Eden St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Dryden N.Y.	April [illegible], 1924

20-UNDERTAKER.	ADDRESS
Wm Cook	502 E Fort Ave

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 21 Ward) 101-00

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma D Mendell

(a) Residence No. 1115 Wards St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed,~~ or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George Mendell

6-DATE OF BIRTH (month, day and year) May 4 - 1882

7-AGE 41 yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER John Byrnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER Fannie Bell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto Md

14- (Informant) George Mendell

(Address) 1115 Wards St

15-

Filed PR 9 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 8-24

17- I HEREBY CERTIFY, That I attended deceased from April 6 1924 to April 8 1924

That I last saw h alive on April 8 1924

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical findings

(Signed) S. Goldman M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL, Apl 11 1924

20-UNDERTAKER John F Cowan & Son Carl F Cowan

ADDRESS 901 Holden St

~~Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.~~

Spec.—1-10-21—M&T—1500 Bks.

D 85757

HEALTH DEPARTMENT—CITY OF BALTIMORE D 85757

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick P. Healey

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? Born in Ireland yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Healey

6 DATE OF BIRTH (month, day, and year) Unknown. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	61	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 32

(b) General nature of industry, business, or establishment in which employed (or employer) Fire work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland

PARENTS

10 NAME OF FATHER Thomas Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Ireland

12 MAIDEN NAME OF MOTHER Catherine Kenny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) Ireland

14 Informant Records Of Mt Hope Retreat

(Address) Mt Hope Md

15 Robert P. Harrison, Registrar

Burial Permit Clerk

R 9 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1913, to Apr. 7, 1924, that I last saw him alive on Apr 6, 1924, and that death occurred, on the date stated above, at 5. 10. A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis - Complicated by Endocarditis

abt (duration) 0 yrs. 0 mos. 15 ds.

CONTRIBUTORY (Secondary) Chr Dyspepsia Psychosis

abt (duration) 11 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Lowery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Apr 10th 1924
20 UNDERTAKER John P. Cowan & Son. Ed. J. Cowan	ADDRESS 901 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 P 866
85758

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85758

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 710 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Cotton

(a) RESIDENCE NO. Camp Holabird St., WARD Camp Holabird Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 24 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bennet Riddick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 9 1924 Robert P. Harrison Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to April 8, 1924.

that I last saw her alive on April 8, 1924

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bunn M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth Va — DATE OF BURIAL April 9 1924

20 UNDERTAKER Joseph Adkins — ADDRESS 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85759

CERTIFICATE OF DEATH.

1917 D 85759

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Thomas J Hamilton Jr

(a) RESIDENCE NO. 1959 N Collington Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Hamilton

6 DATE OF BIRTH (month, day, and year) August 24/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman (Trucks)
(b) General nature of industry, business, or establishment in which employed (or employer) Penn. R.R. Yards
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. J. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah Breuzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant Alice Hamilton
(Address) 1959 N Collington

15 APR 10 1924

16 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis - Septic Pneumonia due to pistol shot in abdomen- Homicide.

(Inquest to be held (duration) yrs. April mos. 9/24 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. Scott Carr, M. D.
(Coroner.)

Apr 8/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ave Lorraine Cemetery	April 10 1924
20 UNDERTAKER Robt J Turner Jr's	ADDRESS 1902 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85760

CERTIFICATE OF DEATH.

90 D 85760

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Carey St ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Murphy

(a) RESIDENCE NO. 103 S. Carey Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen D. Murphy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kavanaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mamie Murphy. (Address) 103 S Carey St.

APR 1 01924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th. 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1923 to April 7, 1924, that I last saw him alive on April 7, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Ac. Dilitation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Coolahan, M. D.

4/8, 1924 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 11" 1924
20 UNDERTAKER	ADDRESS 2236
Wm J. Hartwell.	W. Balto St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85761

CERTIFICATE OF DEATH.

57

D 85761

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Setetz Shear

(a) RESIDENCE NO. 545 Lanvallwood Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isadore Shear

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE — Years: 44 — Months: — — Days: — — If LESS than 1 day, ...hrs. or ....min.: 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Records.

(Address)

15 Filed APR 1 01924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1924, to Apr 9, 1924, that I last saw her alive on Apr. 9, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows: Apoplexy Cholelithiasis ~~Cholecystitis~~ with Emphysema

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Duodenal Ulcer

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Apr 1/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding

(Signed) R. J. Phyllis M.D., M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehren Rosedale — DATE OF BURIAL: 4/10 1924

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E Baltimore

Cor.—1-12-23—M&T—100 Bks.

D 85762 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 W. Biddle St. ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Harris

(a) RESIDENCE NO. 520 W. Biddle St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X		11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. W. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lizzie Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lizzie Harris
(Address) 520 W. Biddle St.

15 Filed ....., 192 ..... ROBERT R. KRAUTER, Registrar
APR 8 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ..... yrs. ..... mos. 14 ds.,

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner.)

April 8, 1924 (Address) 20 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. AuBurn Cem.	Apr. 10 1924

20 UNDERTAKER Samuel Hawley ADDRESS 1128 Bank St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Bowler.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85763

CERTIFICATE OF DEATH.

101-001

D 85763

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1149 N. Carey ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bowler

(a) RESIDENCE No. 1149 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Julia Bowler

6 DATE OF BIRTH (month, day, and year) Mar. 13 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 874

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Bowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Hannah Bogby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Juila Bowler. (Address) 1149 N. Carey St.

15 Filed APR 1 01924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 28th 1924, to April 6th 1924, that I last saw him alive on April 6, 1924, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M Hayes M. D.

4/9. 1924 (Address) 513 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. AuBurn CeM.	4/10/24 19

20 UNDERTAKER Sam'L. T. Hemsley. ADDRESS 578 W. Biddle St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85764

CERTIFICATE OF DEATH.

D 85764

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Princeton Pl St. 17 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Taylor

(a) RESIDENCE No. 307 Princeton Pl WARD

(Usual place of abode) (If non-resident give city or town and State)

Leagth of residence in city or town where death occurred 8yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jno. Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Beatrice Taylorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md.

14 Informant Beatrice Brown.
(Address) 307 Princeton Place.

15 Filed ....., 19..... ROBERT R. KRAMES, Registrar
Burial Permit Clerk.

APR 1 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1924

17

I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to April 3, 1924.

that I last saw h alive on April 3, 1924,

and that death occurred, on the date stated above, at 4:30 P. m.,

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Coroner's Examine

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Coroner's Examn

(Signed) [illegible], M. D.

, 19 (Address) 4266 23rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Apr. 10 19

20 UNDERTAKER Sam'l. T. Hemsley. ADDRESS 578 W. Bidd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85765

CERTIFICATE OF DEATH.

179 D 85765

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 Cookson ST., 24 WARD)

2-FULL NAME Catherine Smolinski

(a) RESIDENCE NO. 1410 Cookson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? 46 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Smolinski

6 DATE OF BIRTH (month, day, and year) 7-27-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jules Smolinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs C. Brown.
(Address) 1410 Cookson St.

15 Filed ....., 19.... ..... Registrar

ROBERT P. KRAUTER, Burial Permit Clerk

APR 1 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1924, to April 8, 1924, that I last saw h— alive on April 8, 1924, and that death occurred, on the date stated above, at 10 am P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) E. S. Hurst, M. D.

4-8, 1924 (Address) 801 E. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. Cem.	4-12 1924
20 UNDERTAKER Thos L Stevens	ADDRESS 1512 Fortaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-69

D 85766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 W. Camden St. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Phillip Bisesi.

(a) RESIDENCE NO 131 W. Camden St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) August 15, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	24.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Bisesi.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie Boidy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Marie Bisesi (mother).
(Address) 131 W. Camden Street

15 APR 10 1924 ROBERT H. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

April 9, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 4/10 1924

20 UNDERTAKER J. J. Fahey Sons

ADDRESS 1618. Light St.

CAUSE OF DEATH MUST BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 85767

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
D 85767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 N. Pulton ST.; 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Holmes

(a) RESIDENCE. No. 302 N. Pulton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jos. Holmes

6 DATE OF BIRTH (month, day, and year) Unk.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Unk
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Deshields

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Drski

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant (Address) Mary Holmes 302 N Pulton

15 [illegible] Registrar

APR 1 0 1924

ROBERT P. ARMSTRONG
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7/1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1924 to Apr. 7, 1924
that I last saw h[illegible] alive on Apr. 7, 1924
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:

Toxemia
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.
(Address) 1019 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	April 10 1924
20 UNDERTAKER Mrs R A Elliott	ADDRESS 1725 Ashland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85768 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

D 85768

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3027 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Tyminski

(a) Residence No. 3027 Elliott St., / Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Nov. 7 - 1923

7-AGE.	If LESS than 1 day,
....yrs. 5 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER Stephen Tyminski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER Maggie Blejza

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Stephen Tyminski

(Address) 3027 Elliott St

15- APR 7 01924 ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April-9-24

17- I HEREBY CERTIFY, That I attended deceased from April 5 1924 to April 9 1924

that I last saw h. im alive on Apr. 8 1924

and that death occurred, on the date stated above, at 5-50 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Nathan J. Deichod, M. D.

, 19 (Address) 2038 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St Stanislaus Cem	April 11, 1924

20-UNDERTAKER.	ADDRESS
Stephen J. Stalkowski	120 S. Kenwood Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D 85769

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1254 W 22 ST., 12 WARD)

2-FULL NAME Margaret Mabel Owen

(a) RESIDENCE NO. 1254 W 22 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Horace Owen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Emma F Owen
(Address) 1254 W 22 St

15 [illegible] ROBERT K. KRAUTER, Registrar
Burial Permit Clerk.

APR 7 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 21 1922 to April 9 1924, that I last saw h alive on April 9 1924 and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) 5 yrs. + mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thru Pul Tb

(Signed) J. Walter C Bacon M. D.

4/10, 1924 (Address) 100 E 20 Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 11 1924
20 UNDERTAKER	ADDRESS
W M Routson	2280 N Avenue

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85770

CERTIFICATE OF DEATH.

44 D 85770

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Harford ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Burgelmeister

(a) RESIDENCE NO. 3400 Harford ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Marie Burgelmeister

6 DATE OF BIRTH (month, day, and year) April 26th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature nf industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred A Burgelmeister

(Address) 3400 Harford ave

15 Filed APR 1 0 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to April 9, 1924, that I last saw him alive on April 9, 1924, and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman, M. D.

(Address) R.F.D. Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 12th 1924
20 UNDERTAKER George Schilling & Sons	ADDRESS 112 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-0-19—[illegible]—2000 Bks.

D 85771

HEALTH DEPARTMENT—CITY OF BALTIMORE

No 85771

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 N. Central ave. ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Frank Macullar

(a) RESIDENCE. NO. 1507 N. Central ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Lillian Florence.

6 DATE OF BIRTH (month, day, and year) Jan. 16, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guard. 062

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md. Penitentiary

9 BIRTHPLACE (city or town) Boston
(State or country) Mass.

PARENTS

10 NAME OF FATHER James F. Macullar

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mass.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Lillian F Macullar
(Address) 1507 N. Central ave

15 Filed APR 1 01924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1923, to April 8, 1924, that I last saw him alive on April 8, 1924, and that death occurred, on the date stated above, at 6 05 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the tongue

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastatic carcinoma of neck (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 5, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) Milton C. Lang, M. D.

, 19 (Address) 1705 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 11th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

mation should be carefully supplied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85772

CERTIFICATE OF DEATH.

74-001 D 85772

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

D 85772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 Barnes ST., 7 WARD)

2-FULL NAME Barbara Kucera

(a) RESIDENCE NO. 1625 Barnes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Kucera

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Frank Kucera
(Address) 1625 Barnes St

15 Filed APR 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy
(Fell in yard- no evidence of fracture of skull)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pallen, M. D.
(Coroner.)

Apr 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 11 1924

20 UNDERTAKER Grant Donaldson — ADDRESS 1900 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 83773

CERTIFICATE OF DEATH.

D 85773

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hop... ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Fredrick

(a) RESIDENCE NO. Aron St, Turners Sta. WARD 2nd

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 6 ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Fredrick

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Francis Fredrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 1 01924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to April 9, 1924, that I last saw h[illegible] alive on April 9, 1924, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Infection Right Hand and Arm Acute

(duration) yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Streptococcus Hemolyticus cultured

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 12 1924
20 UNDERTAKER	ADDRESS
Frank Crockett Son	1406 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85774

31 D 85774

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 N. Edew ST., 5 WARD)

2-FULL NAME Ewd Ellis

(a) RESIDENCE NO. 534 N Edew ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (or) WIFE of Geo Ellis

6 DATE OF BIRTH (month, day, and year) June 2, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Queen Anne Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Geo Ellis (Husband.) 534 N Edew St.

15 Filed APR 1 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch, 1923, to April 8, 1924, that I last saw h[illegible] alive on April 7, 1924, and that death occurred, on the date stated above, at 12 [illegible] P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Godey, M. D.

4/9, 1924 (Address) 1424 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem Queen | DATE OF BURIAL 4/10/24

20 UNDERTAKER R C Frost | ADDRESS 1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85775

CERTIFICATE OF DEATH.

~~90~~ ✓

D 85775

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 N. High ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nancy Galloway

(Residence in Baltimore: No. 127 N. High St.; 35 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fem

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, 1 (Month) 11 (Day), 1851 (Year)

7-AGE, 73 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Queen Anne Co. Md.

PARENTS.

10-NAME OF FATHER, Thomas Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nancy Black

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Galloway

(Address) 127 N. High

15- APR 1 0 1924 ROBERT R. KRAUTER,

Filed ....., 191.... Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 7 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from apr 6 1924, to apr 7 1924, that I saw h er alive on apr 7 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

..... (Duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) A. L. Hommetein M. D.

4/9, 1924 (Address) 733 Aisquith St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Albery Cemetery

DATE OF BURIAL, 4/10/24 191...

20-UNDERTAKER P. C. Cross

ADDRESS 1406 W. Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85776

CERTIFICATE OF DEATH.

D 85776 Registered No.

1-PLACE OF DEATH

City of BALTIMORE (No. St. Agnes Hosp St., 10 Ward) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Kavanaugh

(a) Residence No. 1019 E. Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Kavanaugh

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

11- (Informant) Mrs Eliz. Kavanaugh

(Address) 1019 E. Preston St.

12- APR 1 01924 ROBERT M. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-8-1924

17- I HEREBY CERTIFY, That I attended deceased from 3-19 1924 to 4-8 1924

that I last saw him alive on 4-8 1924

and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardio-Renal Disease

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) H. H. Harper M. D

, 19 (Address) 1 Hopkins Place

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem	April 7 1924
20-UNDERTAKER.	ADDRESS
Geo M. Frost & Son	811 N Howard St

In order to carefully safeguard the health of the community, every death must be registered. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Potter

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 85777

CERTIFICATE OF DEATH.

109-00

D 85777

1-PLACE OF DEATH

CITY OF BALTIMORE (No. John Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Virginia Burke

(a) RESIDENCE NO. 847 N. Milton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan - 29 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER William Burke

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Trainor

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Margaret Trainor
(Address) 847 N. Milton Ave

ROBERT R. KRAUTER

15 APR 1 01924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngeal Obstruction- Abcess in region of epiglottic fold.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Potter, M. D.
(Coroner.)

Apr. 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Towns

DATE OF BURIAL Jul 10 192[illegible]

20 UNDERTAKER Wm Cook

ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Potter

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85777

CERTIFICATE OF DEATH.

109-00 D 85777

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) John Hopkins Hospital (ST.) (WARD)

2-FULL NAME Mary Virginia Burke

(a) RESIDENCE NO. 847 N. Milton ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan - 29 - 1924

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha Trainor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Margaret Trainor

(Address) 847 N. Milton

ROBERT H. KRAUTER,

15 APR 1 01924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngeal Obstruction- Abcess in region of epiglottic fold.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. L. Potter, M. D. (Coroner.)

Apr. 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Towers

DATE OF BURIAL: April 10 1924

20 UNDERTAKER: Jos Cook

ADDRESS: 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 85778

Spec. 2-24-27 5.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85778

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 653 Haw St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Charles Mitchell

(a) Residence No. 653 Haw St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ↘ yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Nov 23rd 1879~~ 1879

6-DATE OF BIRTH (month, day and year) ~~Nov 23rd 1879~~

7-AGE, 45 yrs. 5 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto Md (State or Country),

PARENTS.

10-NAME OF FATHER, John Mitchell

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Ueld Hox

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country),

14- (Informant) John R Riley

(Address) 1254 n Dueber

15- Filed APR 1 01924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 5th 1924 to April 8th 24

that I last saw h. alive on April 8th 1924

and that death occurred, on the date stated above, at. 2 A. M.

The CAUSE OF DEATH* was as follows:

acute dilatation of H. Heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute nephritis

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J E Boulton M. D.

4/10/1924 (Address) 3904 Gamewell Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Lakewood Cemetery	Apr 11, 1924
20-UNDERTAKER.	ADDRESS
Wm Leach & Son	E. Monument Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Frederick Heidman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85779 CERTIFICATE OF DEATH. 101-001 D 85779

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Heidman

(a) RESIDENCE NO. 206 E. Fairmount Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 086

(b) General nature of industry, business, or establishment in which employed (or employer) Manager of Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Randolph Heidman

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Lydia Kerns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

115

14 Informant Hospital Records
(Address)

Filed APR 1 01924 ROBERT R. KRAUTER, Burial Permit Clerk.

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/24

17 I HEREBY CERTIFY, That I attended deceased from 4/2/24, 19..., to 4/6/24 19...,

that I last saw him alive on 4/6/24, 19...

and that death occurred, on the date stated above, at 11:30 P.M. m.

The CAUSE OF DEATH* was as follows:

Endocarditis.
Empyema (following Pneumonia) pneu

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.
Cardiac Insufficiency,
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Hebb, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: APR 10 1924, 19

20 UNDERTAKER: Commissioner Health,

ADDRESS

For Wm. F. Worrall

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85779 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ... ST., ... WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME .....

(a) RESIDENCE NO. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant
(Address)

Filed ..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) ... 19

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,

that I last saw him alive on ..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

.....

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ... 19

20 UNDERTAKER

ADDRESS

...ould be carefully supplied. AGE should be ...be properly classified. Exact statement of OCCUPA- ...of certificates.

...OF DEATH in plain terms, so that it may be ...is very important. See instructions on back of ...

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85780 ✓ D 85780

CERTIFICATE OF DEATH. 56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Curtis Spears

(a) RESIDENCE NO. 1324 N. Gilmor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Spears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Emma -------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Johns Hopkins Hospital
(Address)

15 Filed APR 1 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rickets-Malnutrition-Pyloric Stenosis.

(Autopsy at Hopkins Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jos H Waring, M. D.
(Coroner.)

Apr 7/24, 192 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

16953 D 85781 100-001 D 85781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allayrues Mullins

(a) RESIDENCE No. 81 Elizabeth Home ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Walter

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Rosetta ?

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

APR 10 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1924, to Mar 28, 1924, that I last saw him alive on Mar 28, 1924, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Purulent rhinopharyngitis and stomatitis. About 1½ mos ..... ds.
(duration) yrs.

CONTRIBUTORY (Secondary) Bronchopneumonia About 1 mos. ..... ds.
(duration) yrs.

18 Where was disease contracted if not at place of death? St. Elizabeth's Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. H. Mixsell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 10 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85782

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓ D 85782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Woodley ST., 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zepp

(a) RESIDENCE NO. 906 Woodley St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/14/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Horsell Zepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) West minster Md.

12 MAIDEN NAME OF MOTHER Fannie Grimm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster Md.

14 Informant Mother
(Address) City

15 Filed APR 1 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/14, 1924, to 3/16, 1924,
that I last saw him alive on 3/16, 1924,
and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Prematurity 34 wks foetus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Worm Leon, M. D.

4/9, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	3/17/24
20 UNDERTAKER Parents	ADDRESS

be stated EXACTLY. PHYSICIANS should state
be properly classified. Exact statement of OCCUPA-
of certificates.

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of c

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 15 Ward)

Registered No. 40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Minnie Egan.

(a) Residence No. 1805 N. Monroe St St., Ward

(Usual place of abode) about 10

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Harry Egan

6-DATE OF BIRTH (month, day and year) 1891

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do not know

14- (Informant) Harry Egan

(Address) 1805 Monroe St

15- Robert F. Norris Registrar.

R1 01924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 9. 1924

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Feb. 17 1924 to April 9 1924

that I last saw h~~e~~r alive on April 4 1924

and that death occurred, on the date stated above, at 3 ~~P~~ A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY [redacted] Septicaemia

(Secondary)

Pulmonary Tuberculosis for P.T.D. (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/3-1924

Was there an autopsy? No

What test confirmed diagnosis? Phys. Dg & Lab

(Signed) H Harper M. D

, 19 (Address) 18 Egerton Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL, April 11, 1924

20-UNDERTAKER, Harry H. Witzke

ADDRESS 1531 W. Lombard St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85784

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 85784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert + Saratoga ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dominic Moran

(a) RESIDENCE NO. 9 S. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. (Life) ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary Moran

6 DATE OF BIRTH (month, day, and year) Feb 20, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	1½		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Printer 063

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Thomas A. Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Lanahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Robert P. Harrison, Registrar

Burial Permit Clerk

R 1 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 9, 1923 to April 9, 1924.

that I last saw him alive on April 9, 1924.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis + Insufficiency
Auricular Fibrillation
Cardiac decompensation

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Raymond Peters, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Apr 11 1924
20 UNDERTAKER	ADDRESS
Harry A. Britzke	1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Abrams)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85785

CERTIFICATE OF DEATH.

128

D 85785

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N. Parrish ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Mae Abrams

(a) RESIDENCE No. 205 N. Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): Jan - 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Edw Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lottie Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Lottie Jones

(Address) 205 N. Parrish st

15 Filed Robert P. Harrison, Registrar

[Burial Permit Clerk.]

R 1 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8 1927

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1927, to April 8 1927.

that I last saw her alive on April 8th, 1927.

and that death occurred, on the date stated above, at 10.50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Influenza

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 , (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem — DATE OF BURIAL: April 11th 1927

20 UNDERTAKER: A. Jones — ADDRESS: 111 S. Gilmor st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85786 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85786

CERTIFICATE OF DEATH.

9 38

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE. (No. 1702 Gorsuch Ave 9 ....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer S Jester

(a) Residence No. 1702 Gorsuch Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

~~Single~~, Married ~~Widowed~~, ~~or Divorced~~. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Jester

6-DATE OF BIRTH (month, day and year) Jan 3 1860

7-AGE, 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md
(State or Country)

PARENTS.

10-NAME OF FATHER Charles Jester

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country)

12-MAIDEN NAME OF MOTHER Sarah Nelson

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country)

14- (Informant) Margaret Jester
(Address) 1702 Gorsuch Ave

15- Filed APR 1 01924 19? Robert P. Harrison, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan, 1922, to April 9, 1924, that I last saw him alive on April 9, 1924, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? ~

(Signed) F. J. Kinsey, M. D.

4-10, 1924 (Address) 2700 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. April 11, 1924

20-UNDERTAKER. CHENOWETH & SON ADDRESS 847 CHESTNUT AVE

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No 812 Berry St St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Rebecca Ann Hare

(a) Residence No... 812 Berry St St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 31 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Mill Hand

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 886

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md
(State or Country),

PARENTS.

10-NAME OF FATHER Wm H Hare

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country),

12-MAIDEN NAME OF MOTHER Susan A Wink

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country),

14-

(Informant) Wm H Hare

(Address) 812 Berry St

15-

Filed..... Robert P. Harrison,
Registrar.

PR 1 01924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apl 10 1924

17- I HEREBY CERTIFY, That I attended deceased from July 5, 1923, to Apr 10, 1924, that I last saw h.. alive on Apr 9- 1924 and that death occurred, on the date stated above, at 10.5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

4/10/24 (Address) 846 W 36 St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Manchester, Carroll | DATE OF BURIAL, Apl 13 1924

20-UNDERTAKER ADDRESS
CHENOWETH & SON,
2617 CHESTNUT AVE.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85788

CERTIFICATE OF DEATH.

31 D 85788

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Eisen St. ST., 22 WARD)

2-FULL NAME Clarence Johnson(C).

(a) RESIDENCE NO 610 Eisen St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, ~~widowed, or divorced~~— HUSBAND of (or) ~~WIFE of~~ Mary Johnson(C).

6 DATE OF BIRTH (month, day, and year) March 29, 1896.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	--	11	

8 OCCUPATION OF DECEASED 040

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer.

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mary Johnson(C)(wife).

(Address) 610 Eisen St.

15 APR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis.

Oedema of the Lungs..

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

April 9, 1924 (Address) 1017 St Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Blair. Fairfield. Co. S. C	Apr 12 1924
20 UNDERTAKER John A. Trader	ADDRESS 142 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85789

CERTIFICATE OF DEATH.

1601

74

D 85789

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 W Lanvale ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amanda Chesson

(Residence in Baltimore: No. 519 W Lanvale St.; 61 yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, (Month) (Day) (Year) 1863

7-AGE, 61 yrs. ✓ mos. ✓ ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Jno Mayo

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER, Mahala Mayo

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Chesson

(Address) 519 W. Lanvale

15-

APR 11 1924

Burial Permit Clerk

ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 10th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 6th 1924, to April 10th 1924, that I saw h- alive on April 8th 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. ✓ mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Heart Asthenia

(Duration) yrs. mos. 4 ds.

(Signed) A. B. Carouth M. D.

Apr 10th, 191... (Address) 1512 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs. .....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Apr 12, 1924

20-UNDERTAKER John H. Toadvine — ADDRESS 142 Ostend St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85790

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 85790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1214 St. Paul ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Stockton Buzby

(a) RESIDENCE NO. 1214 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 16th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Seventy-Four	One	Twenty-two	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Mfgs. Agent

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER David T. Buzby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington, Del.

12 MAIDEN NAME OF MOTHER Mary M. Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

14 Informant Stockton Buzby Jr.

(Address) 1214 St. Paul St.

Filed APR 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from APRIL, 1923, to April 10th, 1924,

that I last saw him alive on April 10th, 1924,

and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Approximate (duration) 3- yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thomas L. Shearer, M. D.

Ap. 10th, 1924 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 12 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son	6 Lanvale & McCulloh

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85791

100-001

D 85791

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 Myrtle ave ST., 17 WARD)

2-FULL NAME Bernice O Queen

(a) RESIDENCE NO 410 Myrtle ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Colored

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Queen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Catherine Queen
(Address) 410 Myrtle ave.

15 Filed APR 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained hy said Inquest find that said deceased came to her death ~~(came to death by means of inquiry.)~~ on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) A K Gough, M. D.
(Coroner.)
4-8, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 10 1924
20 UNDERTAKER Brown & Eveland	ADDRESS 1940 Aisquith st

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85792

CERTIFICATE OF DEATH.

1924 D 85792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rear 802 S-2nd St. St., 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannah C. Krueger.

(a) RESIDENCE NO. 900 S- 6th St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 9 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Edw Krueger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Johannah Young

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Edw Krueger
(Address) 900 S 6th St

15 APR 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tub. of Thyroid use
less Prol.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo. C. Yates, M. D.
(Coroner.)

Apr 8, 1924, 192 (Address) 143 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Apr 10 1924

20 UNDERTAKER John Welsh

ADDRESS 2008 Aliceanna.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec— 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85793

CERTIFICATE OF DEATH.

129 D 85793

1-PLACE OF DEATH

City of BALTIMORE: (No. 343 S Monroe St., 19 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Francis Ranger

(a) Residence No. 343 S. Monroe St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John F. Ranger

6-DATE OF BIRTH (month, day and year) Dec. 15-1852

7-AGE. 71 yrs. 3 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). At home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). S. Carolina

PARENTS.

10-NAME OF FATHER, William Arnold

11-BIRTHPLACE OF FATHER (city or town) (State or Country), S. C.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), S. C.

14-(Informant) John F. Ranger

(Address) 343 S. Monroe St.

15-Filed APR 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1924 to April 9 1924

that I last saw her alive on Apr 8 1924

and that death occurred, on the date stated above, at 4.45 A M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) M. J. Hamer M. D

4.10, 1924 (Address) 1822 W Baltimore St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. Apr. 14, 1924

UNDERTAKER George E. Schwab — ADDRESS 1101 Eutaw Ave.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85794

HEALTH DEPARTMENT—CITY OF BALTIMORE

179

D 85794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 S. Clinton ST., 26 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor T. Haynes.

(a) RESIDENCE NO. 343 S. Clinton St ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George N. Haynes.

6 DATE OF BIRTH (month, day, and year) Febr. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John F. Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Twidway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) George N. Haynes 343 S. Clinton St

Filed APR 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1923, to April 8, 1924

that I last saw him alive on April 7, 1924

and that death occurred, on the date stated above, at 7.55 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

4-10-1924 (Address) 3104 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	April 11 1924
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 Lexington

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85795

100-001

CERTIFICATE OF DEATH.

D 85795

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 702 S Robinson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Lubb

(a) Residence No. 702 S Robinson St., 1 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1923 Feb 18

7-AGE. 1 yrs. 1 mos. 22 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER James T. Lubb

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Mary Zimmerer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) James T. Lubb

(Address) 702 S. Robinson St

15- Filed APR 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 9-24

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 9, 1924, that I last saw h.. alive on April 9, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

Primary (Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) C. L. Lee, M. D.

4/10, 1924 (Address) 2701 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	April 11, 1924
20-UNDERTAKER.	ADDRESS
Lilly & Zile	403 S. Wolfe St

Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85796

CERTIFICATE OF DEATH.

100-001 ✓ D 85796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3911 Fait Ave ST., 7th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy M. Hastings.

(a) RESIDENCE No. 3911 Fait Ave ST., 7th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
✓		8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William G. Hastings

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Clara Fuchs.

13 BIRTHPLACE OF MOTHER (city or town) Ohio.
(State or country)

14 Informant William G. Hastings
(Address) 3911 Fait Ave.

15 Filed APR 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to April 10, 1924,

that I last saw her alive on April 10, 1924

and that death occurred, on the date stated above, at 4.00 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	April 12 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Arthur)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85797

100-02

D 85797

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 617 S. Luzerne St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Arthur

(a) Residence No. 617 S. Luzerne St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 3rd 1922

7-AGE. 1 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)..... gd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Stephen Authers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Rosa Nork

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Stephen Authers

(Address) 617 S. Luzerne St.

15- Filed APR 11 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 9th 24

17- I HEREBY CERTIFY, That I attended deceased from March 24 1924 to April 9 1924

that I last saw h alive on April 9 1924

and that death occurred, on the date stated above, at 8 57 P. m.

The CAUSE OF DEATH* was as follows:

Bron Pneumonia

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Primary

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? h

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) W L Long M. D

4/10 1924 (Address) 240 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel Cem. DATE OF BURIAL, April 11 1924

20-UNDERTAKER, Lilly & Zeiler ADDRESS 4038 Wolfe St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 49

D 85798

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1405 E. Fayette St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Benj. Isaacson.....

(a) Residence No. 1405 E. Fayette St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Isaacson

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
50 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)..... 014

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Russia

14-

(Informant) Sarah Isaacson

(Address) 1405 E. Fayette St.

Filed APR 11 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-11-24

17- I HEREBY CERTIFY, That I attended deceased from May, 1923, to April 10th, 1924, that I last saw him alive on April 10th, 1924, and that death occurred, on the date stated above, at 7.30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs

.....(Duration).....yrs. 11 mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Joseph J. Kurtzberg, M. D.

, 19 (Address) 3219 Pennsylvania

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Rosedale	4-11-, 19 24
20-UNDERTAKER.	ADDRESS
Jacob Levin	1439 E. Balto

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85799

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 649 N. Lafayette Ave. WARD 17)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Douglas Johnson

(a) RESIDENCE No. 649 N. Lafayette Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE: Years 41; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Holmes Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Veranza Wilson

(Address) Balto. Co.

Filed APR 11 1924 ROBERT R. KRAUTER, Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 6, 1924, to April 9, 1924, that I last saw him alive on April 9, 1924, and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) arterio Sclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F. Claudius M. D.

Apr 10, 1924 (Address) 1500 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: April 11 1924

20 UNDERTAKER: Sam'l H. Grace & Son — ADDRESS: 1400 Madison

INFORMATION should be carefully supplied. AGE should be CAREFULLY ASCERTAINED. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85800

CERTIFICATE OF DEATH.

124 ✓ D 85800

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 E Federal ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anastatia Krichton

(Residence in Baltimore: No. 1212 E Federal St. 84 yrs., 4 mos. 15 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, November 24, 1839 (Month) (Day) (Year)

7-AGE, 84 yrs. 4 mos. 15 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Andrew Barranger

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Sarah Litzinger

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wife A. Krichton

(Address) 1212 E. Federal st

15- APR 11 1924 ROBERT R. KRAUTER, Clerk.

Filed....., 191.....

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from MAR 8 - 1924 191 , to APR 8 - 1924 191 , that I saw her alive on APR 8 - 1924 191 , and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

..... (Duration) ....yrs. 1 mos. 7 da.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (Duration) ....yrs. ....mos. ....da.

(Signed) ..... M. D.

APR 9 - 1924 (Date) (Address) 228 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Parkwood Cemetery — DATE OF BURIAL, April 9, 1924

20-UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85801

CERTIFICATE OF DEATH.

113 D 85801

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 849 Lemmon st ST., 18 WARD)

2-FULL NAME Mary Bitzer Cooper

(a) RESIDENCE NO 849 Lemmon st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			3 weeks	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Richard Cooper

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 ~~MAIDEN NAME OF~~ MOTHER Hopkinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Mother
(Address) 849 Lemmon st

15 Filed APR 11 1924 ROBERT R. KRAUSER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition - Gastro Enteritis

3 wks
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Forman, M. D.
(Coroner.)

4-30, 1924 (Address) 117 W Lexington st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND
Commissioner of Health

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 85802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D 85802

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 109 Broad Ave ST., 3 WARD)

2-FULL NAME Isaac Hall

(a) RESIDENCE No 109 Broad Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 36 Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown 3/8/24
(State or country)

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Pallie Duffy
(Address) UNIVERSITY OF MARYLAND.

15 Filed APR 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Toxemia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) ... yrs. ... mos. ... ds.

(Signed) Geo Clinton Bladen, M. D.
(Coroner.)

192 (Address) 1436 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL APR 11 1924 192

20 UNDERTAKER

ADDRESS

Commissioner of Health.

1920 THE MORGAN PRINTING CO.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Berkow)

D 85803 HEALTH DEPARTMENT—CITY OF BALTIMORE 65-001 D 85803

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St. & Portland Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Berkow

(a) RESIDENCE NO. 2201 Baker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Lacharutzky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Andrew Block (Address) 2201 Baker St

15 APR 11 1924 RUDOLPH R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/7 1924 to 4/10 1924

that I last saw her alive on 4/10 1924

and that death occurred, on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fibroma of Uterus

Operation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Adolph Sonnheimer M. D.

4/10 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL 4/11 1924

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85804

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85804

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 909 Pierce St. St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Scott

(a) Residence No. 909 Pierce St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Femal

4-COLOR OR RACE, Colord

5-Single, Married, Widowed, Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 26-1900

7-AGE, 24 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore City
(State or Country)

PARENTS.

10-NAME OF FATHER Howard Jones

11-BIRTHPLACE OF FATHER (city or town)
(State or Country) Md

12-MAIDEN NAME OF MOTHER Louise Hawkins

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country) Md

14- (Informant) Louise Hawkins

(Address) 909 Pierce St

15-

Filed ....., 192.. ROBERT R. KRAUTER,
Burial Permit (Registrar.

APR 11 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-8-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1924, to Apr. 8, 1924, that I last saw her alive on Apr. 8, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

1
Acute Emphysema
(Following)
(Duration) 1 yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia
(Duration) — yrs. — mos. 28 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical findings etc

4/9/24 (Signed) Thos Lonton, M. D.
(Address) 888 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn Cem	4-12-1924
20-UNDERTAKER. David Easton	ADDRESS 916 Lanvale

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec--12-23-21--E.B.R.S.--400 Eks.

(Bernard Turner) ✓

D 85805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85805

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH Bayview Hospital 17 Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Turner

(a) Residence No. 538 Orford St., ... Ward. North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~(or)~~ ~~WIFE~~ of Jessie Turner

6-DATE OF BIRTH (month, day and year) 1902

7-AGE. 22 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Bayview Hospital

(Address) Balto, Md.

15- Filed APR 11 1924 192 ROBERT R. KRAUSER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 14 19 24 to April 9 19 24

that I last saw h~~im~~ alive on April 9 19 24

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

?

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. W. Schmidt M. D.

4/10 1924 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	4-11- 19 24
20-UNDERTAKER, Daniel Easton	ADDRESS 916 Ea Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85806

CERTIFICATE OF DEATH.

127

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1126 Brener 2d St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Smith

(a) Residence No. 1126 Brener 2d St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1867

7-AGE. 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS.

10-NAME OF FATHER. John Brady

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Anna Bowers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md.

14- (Informant) Ora Pilkerman

(Address) 1126 Brener St

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

Burial Permit

APR 11 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 10 1924

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 10, 1924

that I last saw h.. alive on April 10, 1924

and that death occurred, on the date stated above, at 10:20 P.m.

The CAUSE OF DEATH* was as follows:

Jaundice

(Duration) .....yrs.....mos. 7 ds.

CONTRIBUTORY (Secondary) Obstruction of Gland Duct

(Duration) .....yrs.....mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Thos. L. Woodruff, M. D.

4-11, 1924 (Address) 703 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bush Park Cem

DATE OF BURIAL. 4-13, 1924

20-UNDERTAKER. Daniel Easton

ADDRESS 916 Eq ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

In plain terms, so that it may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

D 85807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85807

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 6 WARD)

2-FULL NAME John Berringer

(a) RESIDENCE No. 128 N. Belnord Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Berringer

6 DATE OF BIRTH (month, day, and year) Feb 17/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer No. 83

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Zachary Berringer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Crwaford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Johns Hopkins Hospital (Address)

15 Filed APR 1 1924, 192 Robert F. Maffett Registrar

Asst. Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia- Acidosis-Secondary Anemia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis-Arterioe sclerosis. (duration) 5 yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pallen, M. D. (Coroner.)

Apr 19/24 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL April 12 1924

20 UNDERTAKER Jas E. Miller — ADDRESS 2334 Hoffman St

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 85808

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

D 85808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3220 Guilford Ave Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Gaither Tucker

(a) Residence No. 3220 Guilford Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 18, 1918

7-AGE. 5 yrs. 10 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Born

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Benj. Ohara Tucker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Grace Gaither

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14-(Informant) Benj. O. Tucker

(Address) 3220 Guilford Ave.

15-

Filed APR 11 1924

Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 30, 1923, to April 9, 1924 that I last saw h.. alive on April 9, 1924 and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma (Embryoma) of Left Kidney

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary & pleural metastasis - myocardial insufficiency (Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Oct 15/23

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam. of Spec. (Kidney) Removed at Operation

(Signed) Louis P. Hamburger M. D

April 10, 1924 (Address) 1207 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cem. DATE OF BURIAL. April 11, 1924

20-UNDERTAKER. John A. Mitchell ADDRESS 120 W. Fayette St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85809 ✓ 1 [illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 58-001 D 85809

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Hodgson ~~Wm. C.~~ M.D.

(a) RESIDENCE No. 269 Grant Ave. Morgantown W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Jos C. Hodgson

6 DATE OF BIRTH (month, day, and year) Jan 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Professor

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Hodgson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Marg Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed APR 11 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 11, 1924, that I last saw him alive on April 11, 1924, and that death occurred, on the date stated above, at 2-29 m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Morgantown W Va

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood examination

(Signed) Trevor Owen, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgantown W Va DATE OF BURIAL April 1924

20 UNDERTAKER Joshua Mitchell ADDRESS 1201 W Fayette St

R 1 1924

mation should be carefully supplied. AGE should be stated EXACTLY. Physicians and others CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85810

CERTIFICATE OF DEATH.

90 D 85810

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E. Mt Vernon Pl. St.) (WARD) 11

2-FULL NAME Margaretta Laurenson Lackey

(a) RESIDENCE NO. 16 E. Mt Vernon Pl. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Milford F. Lackey. ? ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	?	?	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Lady. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Atthome

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Francis Beeston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs Elizabeth C Lackey (Address) 16 E. Mt Vernon

15 Robert F. Harris, .19 Registrar

Burial Permit Clerk.

R 1 1 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 6th, 1924, to April 10th, 1924,

that I last saw h[illegible] alive on April 10th, 1924,

and that death occurred, on the date stated above, at 12 (noon) pm.

The CAUSE OF DEATH* was as follows:

Myocarditis with broken compensation associated with acute Pericarditis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical findings + Symptoms

(Signed) Wm M. Dabney, M. D.

April 14th, 1924 (Address) Ruxton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pl. New Cathedral Cem

DATE OF BURIAL 4-12 1924

20 UNDERTAKER Fenwick Jenkins Undertaking Co

ADDRESS Mitchell & Orchard.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must be able to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85811

CERTIFICATE OF DEATH.

100-001 ✓ D 85811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Colvin ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luigi Ferranti

(a) RESIDENCE NO. 412 Colvin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 7-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Enrico Ferranti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Francesca Onorato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Enrico Ferranti

(Address) 412 Colvin St

15 APR 11 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 9, 1924, to Apr 10, 1924

that I last saw he alive on Apr 10, 1924

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Primary

Bronchus Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. DeStefano M. D.

Apr 11, 1924 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 4/12/24.

20 UNDERTAKER George J. Ruth

ADDRESS 1785 Hoffman

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS' abbreviations may be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85812

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85812

CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Home for Incurables St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lottie M. Miller

(a) Residence No. N.W. cor Guilford Ave & 21 St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 5, 1878

7-AGE. 46 yrs. 1 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Charles Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Emma Tubbels

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Wm H Tubbels

(Address) 8 91 W. Fayette st

15- Filed ..... Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 10 "24

17- I HEREBY CERTIFY, That I attended deceased from Jany ....., 19 22 to Apr 9 ....., 19 24

that I last saw her alive on Apr 8 & 10 ....., 19 24

and that death occurred, on the date stated above, at 1.00 p. m.

The CAUSE OF DEATH* was as follows:

Septicemia and Necrosis of soft parts of Shoulder (Duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Probable Cerebral Thrombosis (Duration) 4 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) P W B Mayo M. D

4/10 1924 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cem. DATE OF BURIAL, April 13, 1924

20-UNDERTAKER, George J. Smith ADDRESS 153 Hollins st

APR 11 1924 Burial Permit Clerk.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

In plain terms, so that it may be properly classified.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85813

CERTIFICATE OF DEATH.

74 D 85813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 895 N. Howard St., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naomi Thomas

(a) RESIDENCE NO. 895 N. Howard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Thomas.

6 DATE OF BIRTH (month, day, and year) April 2, 1878.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46		8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Rhiannon Howard

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John W. Thomas
(Address) 895 N. Howard St.

15 Filed APR 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

April 13 1924 (Address) 700 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence Annapolis Md

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	4-12 1924
20 UNDERTAKER George T. Eaton	ADDRESS 1785 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85814

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bon Secours Hospital 146 REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette W Payson STS. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Cosgrove

(a) RESIDENCE NO. 1737 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malachi Frank Cosgrove

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1893

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co., Md.

PARENTS

10 NAME OF FATHER McKelbin Talbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary E. Bell

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co., Md. (State or country)

14 Informant M. F. Cosgrove (Husband)
(Address) 1737 N. Washington St.

15 Filed 4/10/1924 Robert P. Harrison, Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1924, to April 10, 1924, that I last saw h[illegible] alive on April 10, 1924, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal septicaemia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Apr. 8 E

Was there an autopsy? No

What test confirmed diagnosis? Clin. & Lab. tests

(Signed) H. Mc Dowell M. D.

4/10/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 14 1924
20 UNDERTAKER Margaret G. Flynn	ADDRESS 1422 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2 | D 85815

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 702 Glenwood Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Branham,

(a) Residence No. 702 Glenwood Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred (Unknown) yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5-If married, widowed, or divorced WIFE of (or) HUSBAND of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, About 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stage hand

(b) General nature of industry, business, or establishment in which employed (or employer) No Special Place

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Daniel A. Garner

(Address) 72a E. 23rd

15- Filed Robert P. Harrison, Registrar.

R 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 10-24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1923, to April 10, 1924, that I last saw him alive on April 7, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A. Buchman M. D.

, 19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, April 12, 1924

20-UNDERTAKER. William Cook — ADDRESS 502 E North

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85816 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 3015 Barclay St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T Mayan

(a) Residence No. 3015 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie R Mayan

6-DATE OF BIRTH (month, day and year) Aug 10 1854

7-AGE. 69 yrs. 8 mos. ds. If LESS than 1 day, hrs. or mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John T Mayan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER. Eliza Carroll

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Annie R Mayan (Address) 3015 Barclay St

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 5 1924 to April 10 1924 that I last saw him alive on April 10 1924 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 6 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Byrd, M. D.

4-11. 1924 (Address) 5600 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	April 12 1924
20-UNDERTAKER.	ADDRESS
William Cook Sons	E Baltimore

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85817

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D 85817

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Arbutus ave ST., Lakeland 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cassell Price Lakeland

(a) RESIDENCE NO. Arbutus ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — child.

6 DATE OF BIRTH (month, day, and year) Apr 9-1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hr. or ... min.
	[illegible]	[illegible]	9/1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (all)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Lakeland (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas A Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence E. Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Florence E. Price (Address) arbutus ave

15 Filed ... 19 Robert P. Harrison, Registrar

R 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9-1924

17

I HEREBY CERTIFY, That I attended deceased from 4-9-, 1924, to 4-10, 1924,

that I last saw him alive on 4-9-, 1924,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Bad condition of blood

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W B Hall, M. D.

, 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apr 12 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 North Eu

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Sipling)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85818

CERTIFICATE OF DEATH.

101-001 ✓ D 85818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Bath Ave ST. 92 W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola allen Sipling

(a) RESIDENCE No. 8 W Lee St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (WIFE of): John Sipling

6 DATE OF BIRTH (month, day, and year): Jan 18- 1888

7 AGE: Years 36 Months 2 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ 03

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Camden NJ

PARENTS

10 NAME OF FATHER: James allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): ✓

12 MAIDEN NAME OF MOTHER: ✓

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ✓

14 Informant: Mr. John Sipling

(Address) E West Lee St.

15 R 1 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/11 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/9/24, 19..., to 4/11/24, 19..., that I last saw h[illegible] alive on 4/11/24, 19..., and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul A Roth Jr M. D.

, 19 (Address) 1629 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 14 1924

20 UNDERTAKER: W. Cook — ADDRESS: 502E Madison

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85819

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85819

CERTIFICATE OF DEATH.

161-004

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Brdg. Gen. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Kipling

(a) RESIDENCE No. S. W. Lot ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	13 hrs. 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Kipling

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Vida Allen

13 BIRTHPLACE OF MOTHER (city or town) Camden, N. J. (State or country)

14 Informant Mr. John Kipling

(Address) S West Jefferson St.

15 R 1 1924 Robert P. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10 24, 19, to April 11 24, 19, that I last saw her alive on April 11 24, 19, and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows: Premature Parturition (6½ mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1629 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 14 1924
20 UNDERTAKER Wm. Cook	ADDRESS 502 E. Hoffman Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PREVIOUS OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85820

CERTIFICATE OF DEATH.

D 85820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3505 Carodale Ave ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Van Wagner

(a) RESIDENCE. No. 3505 Carodale Ave ST. WARD. 5 yrs.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed, or ~~divorced~~, HUSBAND of (or) WIFE of: the late Jassie Van-Wagner

6 DATE OF BIRTH (month, day, and year): Aug 11, 1844

7 AGE: Years 79 yrs. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, md.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Elizabeth Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Mabel Gartner

(Address) 3505 Carodale ave

15 Filed R 1 2 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1, 1919, to April 11, 1924, that I last saw her alive on April 8, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right breast. following Intra canicular Papilloma.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Maurice E. Shamer, M. D.

4/11, 1924 (Address) 3300 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westerne Cemetery — DATE OF BURIAL: April 12 1924

20 UNDERTAKER: Richard F. Burley — ADDRESS: 1108 Guilford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. Donald E. Holbrunner

D 85821

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 D 85821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald E. Holbrunner

(a) RESIDENCE NO. 642 Crawford st ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 14-1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	4	26	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Thomas A. Holbrunner

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mamie Fabian

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Records

(Address)

15 Filed Robert P. Harrison, Registrar

R 1 21924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1924, to April 10, 1924,

that I last saw him alive on April 10, 1924,

and that death occurred, on the date stated above, at 4.43 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 8 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) L. Wachs, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Apr 12 1924

20 UNDERTAKER Harry H Witzke

ADDRESS 1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85822

CERTIFICATE OF DEATH.

101 98 85822

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 McHenry St ST., 19 WARD)

2-FULL NAME James F. Selby

(a) RESIDENCE NO. 1716 McHenry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma A. Selby

6 DATE OF BIRTH (month, day, and year) Nov 7, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	67	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas J. Selby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jane Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma A. Selby
(Address) 1716 Tuckerman St

15 Robert F. Maffett, 19 Registrar

R 1 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4th, 1924, to April 9th, 1924,

that I last saw him alive on April 9th, 1924,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency 1

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. M. Barber, M. D.

April 11th, 1924 (Address) 111 E. Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

DATE OF BURIAL 4-12 1924

20 UNDERTAKER Harry D. Wilzbach

ADDRESS 1531 W. Lombard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85823

CERTIFICATE OF DEATH.

74-004

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Higgins

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Sigle

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Municipal Hospital

(Address)

15- Filed Robert P. Harrison, Registrar.

R 1 2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-7-24

17- I HEREBY CERTIFY, That I attended deceased from 4-2, 1924 to 4-7, 1924 that I last saw him alive on 4-7, 1924 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Right Hemiplegia (Cerebral Thrombosis)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Drace, M. D.

4-10, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 4/12, 1924
20-UNDERTAKER.	ADDRESS 318 Light St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85824

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Talbot Johnson Jr

(a) RESIDENCE NO. Aberdeen - N C ST., WARD N. L. H.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 16-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aberdeen - N.C

PARENTS

10 NAME OF FATHER J. Talbot Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Kate Holcomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Connecticut

14 JOHNS HOPKINS HOSPITAL Informant (Address)

15 Robert P. Harrison, Burial Permit Clerk Registrar

APR 12 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 9 1924, to Apr 11 1924, that I last saw him alive on Apr 11 1924, and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Lymphoid Leukaemia

(duration) — yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Acute otitis media and mastoiditis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. V. Bunn, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ABERDEEN, N.C.

DATE OF BURIAL 4/12 1924

20 UNDERTAKER ROBERT BROOKS SON

ADDRESS CALHOUN HOLLINS ST

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D 85825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Yaskel

(a) RESIDENCE NO. 3103 O'Donnell ST., (O'Donnell st.) WARD Sykesville Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos 11 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Henry Yaskel

6 DATE OF BIRTH (month, day, and year) Mar 24 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Eshoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Yaskel

(Address) 3103 O'Donnell St.

R 1 2 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1924

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1924 to April 9, 1924.

that I last saw her alive on April 9, 1924,

and that death occurred, on the date stated above, at 4.10 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary) Infected Ovarian Cyst (duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of April 2, 24

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. Adler Friedheim M.D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md.	April 12 1924
20 UNDERTAKER J. R. Frees	ADDRESS Sykesville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85826

D 85826

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Baltimore and Payson Sts.

CITY OF BALTIMORE: NO. German Aged Home ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)*

2-FULL NAME Mary E Denson

(a) RESIDENCE. NO. German Aged Home ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan 30 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Gustav Dallon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Caroline Destroff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant German Aged Home Records.

(Address) Balto and Payson Sts

15 Filed APR 21 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17

I HEREBY CERTIFY, That I attended deceased from 4/7/24 . 1924 . to 4/10/24 . 1924 . that I last saw he alive on 4/9/24 . 19 . and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 2. ds.

CONTRIBUTORY (Secondary) Age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) John L Wolff . M. D

. 19 (Address) 1843 W Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Apr. 12 1924
20 UNDERTAKER Joseph D. Cook	ADDRESS 1003 W Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr. Wilhelmine Edmondson Coroner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85827

CERTIFICATE OF DEATH.

3 D 85827

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 243 St. Paul St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph B. Schaefer

(a) Residence No. 243 St. Paul St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Oct 7-1897

6-DATE OF BIRTH (month, day and year)

7-AGE 36 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Cargo Man

(b) General nature of industry, business, or establishment in which employed (or employer)... Western Md R R

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS.

10-NAME OF FATHER Reinhardt Schaefer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Bertha Schumacher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Anna Schaefer

(Address) 243 St. Paul

15-Filed APR 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 11-24

17-I HEREBY CERTIFY, That I attended deceased from Mar 11, 1924, to April 10, 1924

that I last saw him alive on April 10, 1924

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

2

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) X

X (Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W Ken Williams M. D.

, 19 (Address) 610 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL April 14 1924

20-UNDERTAKER, H. B. Shepherd

ADDRESS 2236 Eutaw

Exact statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 85828

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 1179

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 710 N. Gilmor St., WARD)

2-FULL NAME Frank J. Sauerwein

(a) RESIDENCE NO. 2132 E. Vine St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy Sauerwein

6 DATE OF BIRTH (month, day, and year) Oct 1st 1880

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Edward Sauerwein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Louise Klumm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Mrs. L. Sauerwein 2416 N. Bond St

15 Filed Apr 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-24

I HEREBY CERTIFY, That I attended deceased from 4-7-24, 19..., to 4-11-24, 19...

that I last saw him alive on 4-11-24, 19...

and that death occurred, on the date stated above, at 12 25 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of 4-7-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins M. D.

, 19 (Address) 710 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cemetery | DATE OF BURIAL April 14 1924

20 UNDERTAKER J. B. Hilpert | ADDRESS 2256 Eutaw Ave

R 1 2 1924

BE SURE ENTRIES ARE COMPLETE. Information should be carefully supplied. Any error should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 85829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at 90 1924 Registered No. C.....

City of BALTIMORE: (No. St. Agnes Hospital St. 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Brown

(Residence in Baltimore: No. 2205 Arlton St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. March 16 1901
(Month) (Day) (Year)

7-AGE. 23 yrs. mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Scrapper
(b) General nature of industry, business, or establishment in which employed (or employer) Wilson Mfg Co

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Frank Brown

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Wilhelmina Koslowski

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Brown

(Address) 2205 Arlton

15- Robert P. Harrison,
Registrar.

R 1 2-1924 192 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 9th 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound Through Heart & Aorta

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Fenton M. D.
(Coroner.)

April 11 1924 (Address) 700 Chas St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Gardens DATE OF BURIAL April 14 1924

UNDERTAKER, H B Kluppert ADDRESS 2136 Eutaw Pl

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 85830

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85830

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 1112 W. Fayette St. ST. 18 WARD.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Knipe Clifford

(a) RESIDENCE. No. 1112 W. Fayette ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James H. Clifford

6 DATE OF BIRTH (month, day, and year) Oct 16-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Knipe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Elizabeth Bandom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) James H. Clifford 1112 W. Fayette St.

15 Filed ..... 19 Robert F. Marshall Registrar

R 1 21924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 11- 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7 1924 to April 11 1924

that I last saw her alive on April 11 1924

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ✓ yrs. ✓ mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis, Valvular Heart disease & Interstitial Nephritis (duration) ✓ yrs. Over 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Fahle M. D.

(Address) 1208 W. Fayette St.

Apl 11 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	April 14 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85831

D 85831

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lutz

(a) RESIDENCE NO. 3702 Lauretta Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11-24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Vernon Lutz

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Helen Hick

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Vernon E. Lutz

(Address) 3702 Lauretta Ave.

15 Filed APR 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1924 to April 11, 1924.

that I last saw him alive on April 11, 1924,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Compression Causing Asphyxia during delivery.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Singenauf, M. D.

4/11, 1924 (Address) 1613 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 4-12-24

Apr 12 1924

20 UNDERTAKER Henry Lutz

ADDRESS 1203 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85832

D 85832

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 122 Winter Street. ST., 23 WARD)

2-FULL NAME Emma Blake(C).

(a) RESIDENCE NO 122 Winter Street. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. -- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Peter Blake(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Ella Blake(C)(cousin).
(Address) 32 W. Cross Street.

15 Filed R 1 2 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

April 12, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cd	4/12 192 4
20 UNDERTAKER Isaiah Brownston	ADDRESS 1614 W Monroe St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 85833

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 D 85833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 E 28th St., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ophelia Stokes

(a) RESIDENCE NO. 633 E 28th St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] 10 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Caruthus Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Bunch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. R. G. Elliott

(Address) 1323 Carlander

15 Filed ..... Robert P. Harrison, Registrar

R 1 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1924

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to April 8, 1924.

that I last saw h— alive on April 8, 1924.

and that death occurred, on the date stated above, at 5-30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Ted. Odell, M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 10 24
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1323 Carlander

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85834

49 D 85834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 959 N. Chester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Bartunek

(a) Residence No. 959 N Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bartunek

6-DATE OF BIRTH (month, day and year)

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 180

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Vaclav Bartunek

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

11- (Informant) Anna Bartunek

(Address) 959 N. Chester st

15- Robert F. [illegible]

Filed ..... 192..... Registrar.

R 1 21924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 11 24

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1923 to April 11 1924

that I last saw h... alive on April 11 24

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

2 (Duration) yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Lyons M. D.

4/13/24 19 (Address) 1201 Eutaw pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oakhill	19 24
20-UNDERTAKER. Frank E Ockershausen	ADDRESS 1906 Eutaw pl

Exact statement of OCCUPATION is very important. Be sure to answer in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85835 X 148 D 85835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Brown

(a) RESIDENCE NO. Chestertown Md. ST., WARD Chestertown Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm W. Brown

6 DATE OF BIRTH (month, day, and year) April 4th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	-	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Goss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Clara Ordin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Univ. Hosp. Records (Address) Lombard & Greene Sts. Balto

15 FILED APR 12 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1924, to April 10, 1924, that I last saw h[illegible] alive on April 10, 1924, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pre-eclamptic Toxemia

Post-Partum Eclampsia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) David R. Newcomer Jr. Intern, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 12, 24
20 UNDERTAKER	ADDRESS
Fredk Lassahn & Sons	Fullerton

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85836

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85836

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2818 N Calvert St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gwendolyn Louise Johnson Gettier

(a) Residence No. 2818 N Calvert St., 12 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? 19 yrs. 2 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) January-24-1905

7-AGE. 19 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School-Girl

(b) General nature of industry, business, or establishment in which employed (or employer) Schooling at

(c) Name of employer Goucher College

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Stany L. Gettier

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Ida Belle Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mr. S. L. Gettier (Father)

(Address) 2818 N Calvert St. City

15- Robert P. Harrison, ..., 19.....

Registrar.

R 1 21924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr.-10-1924

17- I HEREBY CERTIFY, That I attended deceased from March 14th 1924, to April 10, 1924

that I last saw her alive on April 10, 1924,

and that death occurred, on the date stated above, at 7.45P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ....yrs. ....mos. 28 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Biological (Widal)

(Signed) August Horn, M. D.

, 19 (Address) 40 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cemetery	Apr 12, 1924
20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUP... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85837

D 85837

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2702 Elmora Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lida Higby Elmer

(a) Residence No. 2702 Elsinore Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) June 12 1847

7-AGE. 76 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer..... None

9-BIRTHPLACE (city or town) (State or Country), Pittsburg Pa

PARENTS.

10-NAME OF FATHER, Lewis Elmer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York

12-MAIDEN NAME OF MOTHER Mary Wickersham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

11- (Informant) Ida V. Ashbury

(Address) 2702 E. Elsinore Ave

13- Filed APR 21 1924 19?? Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-10-24

17- I HEREBY CERTIFY, That I attended deceased from 6/1, 1923, to 4-10, 1924

that I last saw h.. alive on 4-10 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

General toxemia

Cardiac insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Cavernous Metastasis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ..... Was

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Carey R. Fehrenbach M. D

4/11, 1924 (Address) 2506 Harlem

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	April 12, 1924
20-UNDERTAKER.	ADDRESS
H. J. Thurston	North Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85838

11-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1915 Mosher St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Plumley

(a) Residence No. 1915 Mosher St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Doe Plumley

6-DATE OF BIRTH (month, day and year) Feb 22 1836

7-AGE. 88 yrs. 1 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer). Real Estate

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Vermont

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-(Informant) Mrs James B Harnell

(Address) 1915 Mosher St

15-Filed Apr 12 1924 Robert P. Harris, Registrar.

R 12 1924

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 11-24

17- I HEREBY CERTIFY, That I attended deceased from April - 5 1924 to April - 10 1924 that I last saw him alive on April 10 1924 and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia,

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Marion W Shoaf, M. D

4.10., 1924 (Address) 806 Hilton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL. April 12, 1924

20-UNDERTAKER. Wallichner & Son — ADDRESS Walbrook

Exact statement of OCCUPATION is very important. Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 85839

STATE OF MARYLAND
CERTIFICATE OF DEATH

D 85839

Registration Dist. No. 10 85839

1 PLACE OF DEATH

County D 85839

Village or City Baltimore (No. 94 Chas St., 12 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Stella E Simmons
in city 6 yrs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept 18, 1896 (Month) (Day) (Year)

7 AGE: 27 yrs. 6 mos. 24 da. If LESS than 1 day ..... hrs. or ..... min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed or (employer): —

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Robert Gamber

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Amy R. Bowers

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Hall

(Address) Catonsville - Md.

15 Filed APR 21 1924 Robert P. Harrison Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 11, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 9 1924, to April 11, 1924, that I last saw h[illegible] alive on April 11, 1924, and that death occurred on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. da.

Contributory Secondary

(Duration) yrs. mos. da.

(Signed) H. Von Ehrmann M. D.

April 11 1924 (Address) Catonsville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Deer Park Cemetery — DATE OF BURIAL: April 17, 1924

20 UNDERTAKER: J. F. Elsner — ADDRESS: Ruxton Md

Spec.—1-10-21—M&T—1500 Bks.

Riley Carr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85840

CERTIFICATE OF DEATH.

X 57 V

D 85840

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp X. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Mr Riley Carr

(a) RESIDENCE NO. 213½ Fair Ave ST., Hanover Pa - WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mr.	Wh.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Carr

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm I Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah E Blom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Riley Carr

(Address) 213½ Fair Ave

15 FEE APR 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.12.24

17 I HEREBY CERTIFY, That I attended deceased from 3.29.24, 19..., to 4.12.24, 19...,

that I last saw h~~im~~ alive on 4.12.24, 19...,

and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diabetes, & Diabetic Gangrene (duration) yrs. 2 mos.? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4.9.24

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Jno A Compton, M. D.

, 19 (Address) Hanover Pa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover, Pa

UNDERTAKER Wm Fickus Sons

DATE OF BURIAL April 12 1924

ADDRESS North St Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85841

1-PLACE OF DEATH

City of BALTIMORE: (No. 653 W. Lombard St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ADELLA YURKSTA

(a) Residence No. 653 W. Lombard St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): July 5. 1921

7-AGE. 2 yrs. 9 mos. 7 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): No

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Antany Yurksta

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Lithvania

12-MAIDEN NAME OF MOTHER: Elezabeth Glodutis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Lithvania

14-

(Informant) Antany Yurksta

(Address) 653 W. Lombard Street

Filed APR 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 12 1924

17- I HEREBY CERTIFY, That I attended deceased from April 5 1924 to April 12 1924

that I last saw h. alive on April 12 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John B. Wladowsky M. D.

4/12 1924 (Address) 638 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	April 14 1924
20-UNDERTAKER,	ADDRESS
John Greblauckas	425 S. Paca St.

F.C.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85842

CERTIFICATE OF DEATH.

16 D 85842

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Linecrest Terrace St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Bradley

(Residence in Baltimore: No. 1400 Hollins St.; 82 yrs. .... mos. .... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Sept. (Month) 2 (Day), 1841 (Year)

7-AGE 82 yrs. .... mos. .... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Rowe

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Ellen Burns

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Walter Bradley

(Address) East Orange N.J.

15- Filed APR 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 11th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apl. 1 1924, to Apl. 11 1924, that I saw her alive on Apl 11 1924, and that death occurred, on the date stated above, at 6 25 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) .... yrs. .... mos. 7 ds.

CONTRIBUTORY (Secondary) Old age

(Duration) 2 yrs. .... mos. .... ds.

(Signed) Herbert L. Blake M. D.

4/12, 1924. (Address) 1014 N. Fremont Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, BALTIMORE CEM

DATE OF BURIAL, 4/14, 1924

UNDERTAKER ROBERT BROOKS & SON

ADDRESS COR CALHOUN HOLLINS ST

FUNERAL DIRECTORS & EMBALMERS

S. E. CORNER CALHOUN & HOLLINS STREETS

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 85843

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 85843

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1113 Race ST. 23 WARD)

2-FULL NAME Lizzie Smart

(a) RESIDENCE NO. 1113 Race ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lawrence Boyle

(Address) 1113 Race St

15 Filed APR 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 10/14/ 23 to 4/10/ 24

that I last saw h alive on 4/10/ 24

and that death occurred, on the date stated above at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

7 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchopneumonia

Nephritis (duration) Abt 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Microscop-

(Signed) John Conley, M. D.

4/11/ 24 (Address) 1908 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL April 14 1924

20 UNDERTAKER R. S. Parkhurst

ADDRESS 902 Eastern Ave St

IMPORTANT—This Certificate should be carefully prepared. ANSWERS should be stated EXACTLY. THIS BLANK should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85844

CERTIFICATE OF DEATH.

31 D 85844

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Crawford

(a) Residence No. 1330 Argyle St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1888

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) D.31

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, William Dickerson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Ida Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Municipal Hospital Records

(Address)

15- APR 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-10-24

17- I HEREBY CERTIFY, That I attended deceased from 4-8, 1924, to 4-10, 1924

that I last saw h[illegible] alive on 4-10, 1924

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

4-5 ? (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. + X-Ray

(Signed) Claude C. Drane M. D.

4-10. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Walker Registown Cemetery

DATE OF BURIAL, April 14 1924

20-UNDERTAKER, L. Frank Alexander

ADDRESS 1429 Edmondson Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85845

CERTIFICATE OF DEATH.

10 1 D 85845

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 S. Caroline St ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hall

(a) RESIDENCE NO. 424 S. Caroline ST., 3 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge Md (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Carrie Cooper

(Address) 424 S Caroline St

15 Filed APR 18 1924 ROBERT R. KRAUTER, Burial Permits Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1924, to April 10, 1924, that I last saw him alive on April 10, 1924, and that death occurred, on the date stated above, at 6.20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bernard Harris, M. D.

, 19 (Address) 385 Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury

DATE OF BURIAL April 14 1924

20 UNDERTAKER John W Henderson

ADDRESS 402 E Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85846

CERTIFICATE OF DEATH.

90 D 85846

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N. Carey ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Fisher

(a) RESIDENCE. NO. 1112 N. Carey ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm L. Fisher

6 DATE OF BIRTH (month, day, and year) Jan 8, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Warrick Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Servant

11 BIRTHPLACE OF FATHER (city or town) Warrick Co
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rachel Richardson

13 BIRTHPLACE OF MOTHER (city or town) Warrick Co
(State or country) Virginia

14 Informant Mrs Gertrude Fisher
(Address) 1112 N. Carey

15 Filed ....., 19 .....

ROBERT R. KRAUSS Registrar

APR 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17

I HEREBY CERTIFY, That I attended deceased from October 10 1923 to April 10, 1924.

that I last saw h[illegible] alive on April 10 1924

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of heart

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) John E. G. Lampe M. D.

. 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemy	4/13/24 19

20 UNDERTAKER Samuel T. Hemsley. ADDRESS 578 W. Biddle S

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85847

CERTIFICATE OF DEATH.

D 85847

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 430 W. Biddle ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy C. Cargill

(a) RESIDENCE NO. 430 W Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Marcus Cargill

6 DATE OF BIRTH (month, day, and year) May 8, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Madison Ga

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Charlotte Deacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Wm Cargill

(Address) 620 Park Ave

15 Filed APR 13 1924 19 ... Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 3 . 1924 . to April 10 . 1924.

that I last saw her alive on April 10 . 1924,

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis,

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) W. F. Howell M. D.

4/12 19 24 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem.

DATE OF BURIAL 4/13 1924

UNDERTAKER Samuel F Hemsley

ADDRESS 708 W Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-28—M&T—100 Bks.

D 85848

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 85848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul F. Sauer ~~City Jail~~ Dan Brown

(a) RESIDENCE NO. ~~City Jail~~ Dan Brown WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced (write the word)~~
Male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Carrie Sauer

6 DATE OF BIRTH (month, day, and year) July 14, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ~~City Jail~~ Dan Brown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER John Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Romer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William T. Gilday

(Address) 2503 Druid Hill Ave

15 Filed APR 13 1924 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Due to Acute alcoholism

Contributory Hypertrophy of heart

(Duration) 1 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Nulty, M. D.

Apr 13, 1924 (Coroner.) (Address) 1 E 29 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Apr 14, 1924

20 UNDERTAKER

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85849

CERTIFICATE OF DEATH.

124 D 85849

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. E. Monument ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Bauer Baum

(a) RESIDENCE NO. 1382 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Bauer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abrahem Sirkis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Baltimore St

15 APR 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to April 13, 1924, that I last saw her alive on April 13, 1924, and that death occurred, on the date stated above, at 4:10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 11, 1924

Was there an autopsy? No

What test confirmed diagnosis? Removal of Gall bladder

(Signed) A Adler Goodheimer M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/13 1924

20 UNDERTAKER Jack Levis 1439 E Balto — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85850

D 85850

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St., 18 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Meyer Dubowitz

(a) RESIDENCE No. 1100 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Dubowitz

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tinner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto. Md

15 APR 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. M. Pollen, M. D.
(Coroner.)

Apr 12/24 192 (Address) 508 E?. North A

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/13 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

D 85851

D 85851

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pessie Fine

(a) Residence No. 115 Aisquith Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 84 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION* OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levis

(Address) 1439 Eastaltst

15- APR 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/13/24

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to April 13, 1924, that I last saw h.. alive on April 12 1924 and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Acardiac Acholath

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos J Boughin, M. D.

4/13/24 (Address) 20 Aisquith

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Northwestern Cem	4/13, 1924
20-UNDERTAKER,	**ADDRESS**
Jack Levis	1439 Eastalt

Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85852 — 90 — D 85852

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 11-E-Chase-St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Duncan Bouchelle Cannon

(a) Residence No. 11-E-Chase-St., 11 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 3 mos. ? ds. How long in U. S., if of foreign birth? 82 yrs. 3 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mamie Scott Cannon

6-DATE OF BIRTH (month, day and year): Dec-1841

7-AGE: 82 yrs. 3 mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland.

PARENTS.

10-NAME OF FATHER: John B. Cannon

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Matilda J. Mitchell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland.

14- (Informant) Mrs Augusta S Hanson (cousin)
(Address) 2203 N Calvert St.

APR 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 11-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1924, to Apr 11, 1924, that I last saw him alive on Apr 10, 1924, and that death occurred, on the date stated above, at 11.20 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

1

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(Duration) ....yrs....mos....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam & Clinical

(Signed) Geo M Lear, M. D.

Apr 12, 1924 (Address) 1703 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Co. — DATE OF BURIAL, Apr 13, 1924.

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OF DEATH. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. See Letter

D 85853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85853

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 512 N Arlington St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... David Francis Orr

(a) Residence No... 512 N Arlington St., 18 Ward... Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 70 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Evalynn Mae Sparran Orr

6-DATE OF BIRTH (month, day and year) ~~Feby 27 1845~~ Feby 27, 1843

7-AGE. 81 yrs. 1 mon. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)... Newspaper Man.

(c) Name of employer... none.

9-BIRTHPLACE (city or town) (State or Country). not known Nova Scotia.

PARENTS.

10-NAME OF FATHER, William Orr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), not known Scotland

12-MAIDEN NAME OF MOTHER, Mayant Patry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), not known Scotland

14- (Informant) Mrs. Walynn F. Orr (wife)

(Address) 512 N. Arlington Ave

15-

Filed... 192...

APR 13 1924 ROBERT R. KRAUSER, Secretary.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov ..., 19 23, to April 11, 19 24

that I last saw him alive on April 11, 19 24

and that death occurred, on the date stated above, at 9 20 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Senile debility

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Walter E. Triebsman, M. D.

4/11, 1924 (Address) 2002 N Lemington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, April 14 19 24

20-UNDERTAKER, ~~ROBERT~~ & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCI instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85854

101-001 ✓

101 D 85854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2441 McCulloh ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Hall

(a) RESIDENCE NO. 2441 McCulloh ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia Hall

6 DATE OF BIRTH (month, day, and year) Jan. 27-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter-Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer U. S. P. O.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Single

12 MAIDEN NAME OF MOTHER Elizabeth ~~Hall~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Julia Hall

(Address) 2564 McCulloch St

15 APR 13 1924 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to April 10, 1924

that I last saw h[illegible] alive on April 10, 1924

and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

4/10, 1924 (Address) 1200 E. Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Laurel Cemetery	Apr. 14, 1924
20 UNDERTAKER	ADDRESS 1809
Jno. M. Johnson	Druid Hill

INFORMANT should be careful, supplies. ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85855

CERTIFICATE OF DEATH.

51 D 85855

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 943 N. Ebenezer St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph M. Traunbuecher

(a) Residence No. 943 N. Ebenezer St., 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Jan 16th 1856

7-AGE: 68 yrs. 2 mos. 25 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: John Traunbuecher

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Margaretta Seidler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) Barbara Traunbuecher

(Address) 943 N. Ebenezer St.

15-

APR 13 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 10th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 10 1924 to April 10 - 1924

that I last saw him alive on April 9 1924

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Sepsis Cellulitis Cruris following

ulcer of Hand (Duration) — yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Normal

(Signed) [illegible] M. D

, 19 (Address) 125 E. 12 Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: April 14, 1924

20-UNDERTAKER: Lilly & Zeiler

ADDRESS: 4038 Wolfe St.

Exact statement of OCCUPATION is very important. See instructions on back of certificates. in plain terms, so that it may be properly classified.

D 85856

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 85856

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2649 Maryland St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel K. P. Downes Jr

(Residence in Baltimore: No. 2649 Maryland St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	White	Married

6-DATE OF BIRTH. Feb. 22 1877
(Month) (Day) (Year)

7-AGE. 46 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer): Pack Co.

9-BIRTHPLACE. (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Samuel Downes

11-BIRTHPLACE OF FATHER. (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Ella Hamburger

13-BIRTHPLACE OF MOTHER. (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth D. Downes

(Address) 2649 Maryland ave

15. APR 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 10 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabetes
Pleurisy
Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. H. Mowen M. D.
(Coroner.)

April 11 1924 (Address) 1632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
London Park April 14 1924

20-UNDERTAKER. ADDRESS
H. C. Wiedefeld 914 Greenmt ave

state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 85857

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85857

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 E Federal St ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Eliza Zane

(a) RESIDENCE NO. 2010 E Federal St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND
(or) WIFE of Edward Zane

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER ????? Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER ???? Christopher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Sarah Asher

(Address) 2010 E Federal St

15 [illegible] ROBERT R. KRAUTER, Registrar

APR 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April - 11 - 1924

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1924, to April 11, 1924,

that I last saw her alive on April 10, 1924,

and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Malulence

(duration) yrs. mos. 3 ds. ?

CONTRIBUTORY (Secondary) Myocarditis & Lymfanitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. P. Cannan, M. D.

4-13, 1924 (Address) 1701 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	4/13/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85858

CERTIFICATE OF DEATH.

129 D 85858

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2121 N. Charles ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian S. Turner

(a) RESIDENCE. NO. 2121 N Charles ST., 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. C. Turner

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Robinson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mary W. Robinson
(Address) 2121 Homewood ave

15 Filed APR 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 11 1924

17 I HEREBY CERTIFY, That I attended deceased from apr 8 1924, to apr 11 1924

that I last saw her alive on apr 11 1924

and that death occurred, on the date stated above, at 3-10 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Convulsion & Coma

(Signed) Jno. H. Pearce M. D.

. 19 (Address) 2105 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenmount	April 14 1924
20 UNDERTAKER George J. Smith	ADDRESS 15-37 Hollins St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85859

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85859

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 122 N. Fremont Ave St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen P. McComas

(a) Residence No. 122 N. Fremont Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 27, 1850

7-AGE.	If LESS than 1 day,
73 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Painter

(b) General nature of Industry, business, or establishment in which employed (or employer)..... D

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Stephen McComas

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Angelina Parlett

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Maryland

14-

(Informant). Parlett B. Canton

(Address) 2 S. Broadway

15-

Filed APR 13 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 12-24

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to April 12, 1924,

that I last saw h.im alive on April 12, 1924

and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Myocarditis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. Fenny Glassman, M. D.

April 12 1924 (Address) 2768 Wheeler Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet Cem	April 14, 1924
20-UNDERTAKER.	ADDRESS
George J. Smith	1532 Hollins st

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85860

CERTIFICATE OF DEATH.

90 D 85860

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 65 E Clement St., 24th WARD)

2-FULL NAME John H. Hawkins

(a) RESIDENCE No. 65½ E Clement St., WARD 24

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence J. Mitchell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Platt & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Elias Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth +

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs E. J. Hawkins

(Address) 65 E Clement St

15 APR 13 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 14 1924 to Apr 4 1924,

that I last saw h... alive on Jan 10 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Arteriosclerosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

, 19 24 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 4/7 1924

20 UNDERTAKER [illegible] ADDRESS 1318 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85861 — 101-001 — D 85861

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 Hatherland Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustave Dr Cock

(a) Residence No. 1012 Hatherland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	W Lite	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Dr Cock

6-DATE OF BIRTH (month, day and year) Feb 22 1850

7-AGE.	If LESS than 1 day.
74 yrs. 1 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Brussels Belgium

PARENTS.

10-NAME OF FATHER. John De Cock

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Belgium

12-MAIDEN NAME OF MOTHER. Margaret Heneghet

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Fred De Cock

(Address) 1012 Hatherland Ave

15- Filed APR 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 12 1924

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 12, 1924, that I last saw h[illegible] alive on April 12, 1924, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Hypostatic failure

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Novak, M. D.

, 19 (Address) 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Boston, Mass.	April 13 24
20-UNDERTAKER. Joseph B Cook	ADDRESS. 1003 N. Bath St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85862

CERTIFICATE OF DEATH.

164

D 85862

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 Aisguith Street ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Augusta McClure

(Residence in Baltimore: No. 1047 Aisguith Street St.; 79 yrs., 8 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	WIDOW

6-DATE OF BIRTH. August, 2nd., 1844
(Month) (Day) (Year)

7-AGE. 79 yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... At Home

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)....Charles E. McClure.....

(Address)....1047 Aisgith St.....

15- APR 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 13, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1923, to Apr. 12 1924, that I saw h[illegible] alive on Apr. 12 1924, and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age.

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Thomas H. Magruder M. D.

Apl. 13 1924 (Address) 14 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, GREENMOUNT Cemetery. DATE OF BURIAL, Apr. 16, 1924

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 E. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85863 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 85863

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1460 Stevenson st 24 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alpha V. Mullen.

(a) Residence No. 1460 Stevenson st. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late William Mullen

6-DATE OF BIRTH (month, day and year) Dec 23 1853

7-AGE. 68 yrs. 3 mos. 20 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt

PARENTS.

10-NAME OF FATHER, James Mullen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt

12-MAIDEN NAME OF MOTHER, Jane Smallwood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-(Informant) Mrs. Agnes Thompson

(Address) 1460 Stevenson st.

15-Filed APR 14 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 24

17- I HEREBY CERTIFY, That I attended deceased from Sept 10 19 23 to June 19 24

that I last saw her alive on June 12 19 24

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Thrombosis

(Duration) yrs. mos. 7 days

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. C. Richardson M. D.

(Address) 117 W. 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet Cemetery Hampden	April 15 1924
20-UNDERTAKER.	ADDRESS
Geo. J. Ruth.	1735 Hayford ave.

In plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85864

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85864

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1740 Webster St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. McClonough Jr.

(a) Residence No. 1740 Webster St. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 10. 1924

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 3 ds.	....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER, Thomas A McClonough

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Phila. Pa.

12-MAIDEN NAME OF MOTHER, Margaret Gerhaard.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14- (Informant) Thomas A. McClonough

(Address) 1740 Webster St

15- Filed APR 14 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 9th, 1924, to April 12, 1924,

that I last saw him alive on April 12 7:30 PM, 1924,

and that death occurred, on the ~~date~~ April 13 stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

.....(Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY .....
(Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Susanne Parsons M. D.

, 19 (Address) 1702 Westwood Ave per Bd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cathedral Cem.	April 14 1924
20-UNDERTAKER,	**ADDRESS**
Margaret A. Flynn	1422 Light St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85865

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D 85865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Walsh Jr.

(a) RESIDENCE NO. 1351 Sargeant ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 16 192[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	2	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Walsh

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary [illegible]

13 BIRTHPLACE OF MOTHER (city or town) Canada
(State or country) [illegible]

14 Informant John J. Walsh
(Address) 1351 Sargeant

15 Filed APR 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 th 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6 th, 1924, to Apr. 12 th, 1924, that I last saw him alive on Apr. 12 th, 1924, and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Empyema (right chest)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 4-8-24

Was there an autopsy? No.

What test confirmed diagnosis? X ray, clin. & Lab. tests

(Signed) [illegible], M. D.

4/12/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr 15 1924
20 UNDERTAKER James Dignan & Son	ADDRESS [illegible] St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Herndon.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85866

90 D 85866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Herndon.

(a) RESIDENCE NO. 1300 Division ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant David Easton

(Address) 916 Penna ave

15 APR 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/24 19

17 I HEREBY CERTIFY, That I attended deceased from 4/5/24, 19 ..., to 4/12/24, 19 ..., that I last saw him alive on 4/12/24, 19 ..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardio vascular disease. Mitral insufficiency. Cardiac decompensation.

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia.

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo Herndon Jr., M. D.

, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-14 1924
20 UNDERTAKER David Easton	ADDRESS 916 Penna ave

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. If LESS than 1 day, HOURS or MINUTES. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 100-001 D 85867

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Shields ST.) (14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Athens Jackson

(a) RESIDENCE. No. 1511 Shields ST., WARD.

(Usual place of abode) 26 (Yrs)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Jackson

6 DATE OF BIRTH (month, day, and year) Mch 17 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife - 037

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Elijah Hensley

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country)

12 MAIDEN NAME OF MOTHER Madora Taylor

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Jeanette Taylor, (Address) 1511 Shields

15 Filed APR 14 1924 ROBERT R. KRAUTER, Asst. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to April 11, 1924, that I last saw h.. alive on April 11, 1924, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia.

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

12 (Address) 1209 Preston ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 4-14 1924

20 UNDERTAKER David Easton — ADDRESS 916 Ca ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85868

CERTIFICATE OF DEATH.

X 45 D 85868

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Strange.

(a) RESIDENCE NO. U.S. Marine Hospital ST., WARD

(Usual place of abode) Baltimore Md.

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Strange.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer U.S. Light House Service Washington D.C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Self.

(Address)

15 Filed APR 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11 1924

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1924 to April 11, 1924.

that I last saw him alive on April 11, 1924.

and that death occurred, on the date stated above, at 12 08 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma mesenteric glands ? ?

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydronephrosis right kidney & Nephrectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? D.C. Washington

Did an operation precede death? yes Date of April 4, 1924

Was there an autopsy? yes.

What test confirmed diagnosis? Microscopic report

(Signed) P. H. Foster, M. D.

(Address) U.S. Marine Hospital, Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 4/13 1924

20 UNDERTAKER Sol Spinser & Bro

ADDRESS 427 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85869

CERTIFICATE OF DEATH.

X65-001 D 85869

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital, Balto. Md ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master Carl Owens

(a) RESIDENCE NO. Lutherville, Md Balto Co ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. — mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 3, 1916.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Metuchen (State or country) New Jersey

PARENTS

10 NAME OF FATHER Mr Hamilton Owens

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Von Hartz, Olga.

13 BIRTHPLACE OF MOTHER (city or town) Rutherford (State or country) New Jersey

14 Informant Miss Alice Owens (Address) 1100 N. Eutaw St.

15 Filed APR 14 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1924, to April 13, 1924, that I last saw him alive on April 13, 1924, and that death occurred, on the date stated above, at 10 55 A. m.

The CAUSE OF DEATH* was as follows:

Acute lymphoid leukaemia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Lutherville, Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) G. T. Goff M. D.

. 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL April 14 1924

20 UNDERTAKER Henry H. Jenkins Sons Co

ADDRESS McCulloh & Orchard Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85870

CERTIFICATE OF DEATH.

107-001

D 85870

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hotel Belvedere

CITY OF BALTIMORE, (No. Chas and Chase St., 12 WARD)

2-FULL NAME Wm F. Hall

(a) RESIDENCE NO. Cypress Apart. 905 Lake Drive St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Irene Brown Hall

6 DATE OF BIRTH (month, day, and year) Dec 25 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Wm F Hall Pres.

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Hall

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sophie Lauterbach

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs. Wm F Hall

(Address) Cypress Apts

15 APR 14 1924 ROBERT A. KRAUSE Registrar

Burial Permit Cl...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17 I HEREBY CERTIFY, That I attended deceased from November, 1923, to April 10, 1924,

that I last saw him alive on April 10, 1924,

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Tumor of the Lung

(type unknown)

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Rays

(Signed) Sydney R Muller, M. D.

, 19 (Address) 1900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 14th 1924

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Orchard Sts

INFORMATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85871

CERTIFICATE OF DEATH.

90 D 85871

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Wolfe ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ferkeler

(a) RESIDENCE NO. 916 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Ferkeler

6 DATE OF BIRTH (month, day, and year) June 2nd 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Ferkeler. (Address) 916 N. Wolfe St.

Filed APR 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17

I HEREBY CERTIFY, That I attended deceased from January 10, 1924, to June 12, 1924, that I last saw h/m alive on March 9, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Insufficiency

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Lost compensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb Valk, M. D.

June 12, 1924 (Address) 1033 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	June 14 1924
20 UNDERTAKER E. Schumacher Son	ADDRESS 1037 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85872

CERTIFICATE OF DEATH.

179 D 85872

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 N. Potomac St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Harry Scheff

(a) Residence No..... 114 N. Potomac St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Scheff

6-DATE OF BIRTH (month, day and year) Sept 25, 1887

7-AGE. 36 yrs. 6 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Potter
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer..... Bennett Pottery

9-BIRTHPLACE (city or town)..... Balto
(State or Country)..... Md.

PARENTS.

10-NAME OF FATHER. George Scheff

11-BIRTHPLACE OF FATHER (city or town)..... Balto
(State or Country)..... Md.

12-MAIDEN NAME OF MOTHER, Annie Meyer

13-BIRTHPLACE OF MOTHER (city or town)..... Balto
(State or Country)..... Md.

14- (Informant) Stella Scheff
(Address) 114 N. Potomac St

15- Filed APR 14 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from 1-10-23 19.. to 4-10- 19 24
that I last saw h.. alive on 4-10- 19 24
and that death occurred, on the date stated above, at 5.30 A. m.
The CAUSE OF DEATH* was as follows:

Myocarditis
6 (Duration) .. yrs. 9 mos. .. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(Duration) 1½ yrs. .. mos. .. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Herrmann M. D.
4-11-24 (Address) 1919 E Balto. St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel Cem.	April 14, 1924
20-UNDERTAKER, H. Sander Sons	ADDRESS 1710 East St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH ~~1622 N. Mount~~

CITY OF BALTIMORE: (No. ~~1040 N. Mount~~ ST. 16 WARD)

REGISTERED NO. 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Virginia Rhodes

(a) RESIDENCE. No. 1040 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of John H. Rhodes

6 DATE OF BIRTH (month, day, and year) Nov 20 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Mrs Mary Ellinger Calvert Co Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Eli Helms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co

12 MAIDEN NAME OF MOTHER Nancy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co

14 Informant Minnie Jackson (Address) 1088 N. Arlington Ave

15 Filed APR 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April 4 1924 to April 11 1924

that I last saw h alive on April 10 1924.

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? a

What test confirmed diagnosis? Urinary Test.

(Signed) Jas L. Hooper, M. D.

4/11, 1924 (Address) 3462 Li

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 14 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Wkeel St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85874

D 85874

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 131 W Belvidere Ave ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant James

(a) RESIDENCE. NO. 131 W Belvidere Av ST., WARD. 27

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 13 1924

7 AGE Years Months Days 1 If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Harry James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Detroit Mich

12 MAIDEN NAME OF MOTHER Emma Blenkenger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Father James Harry James 131 W Belvidere Ave

15 APR 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1924, to to Apr 13, 1924, that I last saw her alive on Apr 13, 1924, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Charles J Wells, M. D.

, 19 (Address) 2 W Belvidere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashbury M E Cemetery

DATE OF BURIAL: April 14 1924

20 UNDERTAKER: Reisterstown Md

ADDRESS: Reisterstown Md

J F Ebbins

* CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 85875

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D 85875

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. Hillen Road St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ernest Klingelhofer

(a) Residence No. Hillen Road St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Klingelhofer

6-DATE OF BIRTH (month, day and year) Oct. 4 1835

7-AGE. 88 yrs. 6 mos. 8 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Wetter Germany

PARENTS.

10-NAME OF FATHER Christian Klingelhofer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ger.

12-MAIDEN NAME OF MOTHER Gertrude Manger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ger.

14- (Informant) Mrs Reg. Klingelhofer

(Address) Hillen Road. Towson

APR 14 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 10, 1924, to Apr 12, 1924, that I last saw h.... alive on Apr 12, 1924, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Bronchitis (acute)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Tony Ryan M. D

Apr 13, 1924 (Address) 1162 E. Northern

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Co. DATE OF BURIAL. Apr. 14 1924

20-UNDERTAKER. Wm J Ickes & Sons ADDRESS Towson Md

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

D 85876

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 85876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 Aisquith St ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor D. Weicheldorfer

(a) RESIDENCE NO. 1525 Aisquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Janruary 1/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. Weicheldorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Deacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Wm. Weicheldorfer
(Address): 1525 Aisquith St

15 APR 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia
(Primary)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Baer (Coroner.), M. D.

Apr 14/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 14 192 4

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85877

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1009 S. East Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Betkey

(a) Residence No. Essex, Balto. Co., Md. St., ... Ward.....

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 7 mos. X ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. H. Betkey

6-DATE OF BIRTH (month, day and year) July 6-1861

7-AGE. 62 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Hessemer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14- (Informant) Chas. H. Betkey

(Address) Essex, Balto. Co. Md.

15- APR 14 1924 ROBERT R. KRAUTEN Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 11-24

17- I HEREBY CERTIFY, That I attended deceased from 1/15 1924 to 4/11 1924

that I last saw h alive on 4/11 1924

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

& Oedema of Leves.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) C. A. Reifschneider M. D.

4/11, 1924 (Address) 2939 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
St. Paul's Cemetery	April 14, 1924
20-UNDERTAKER Zirkler & Zirkler	ADDRESS 1739 E. Eager St.

Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85878

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 85878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 323 S. Paysen St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Beal Blankline

(a) Residence No. 323 S. Paysen St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Blankline

6-DATE OF BIRTH (month, day and year) Oct. 31-1855

7-AGE. 69 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) B&O R.R.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Andrew Blankline

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Marcella Durall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant) Annie Blankline

(Address) 323 S. Paysen St

13- Filed APR 14 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 11 / 24

17- I HEREBY CERTIFY, That I attended deceased from April 1 " 19 24 to April 11 " 19 24

that I last saw h.. alive on April 11 " 19 24

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Malignant disease of Rectum

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Lyttant, M. D

, 19 (Address) 211 N. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. McCurdy Cemetery — DATE OF BURIAL. April 13 19 24

20-UNDERTAKER, Josiah Lyfer — ADDRESS 1602 N. North Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lazar Merrenblum

(a) Residence No. 115 Aisquith Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chesna Merrenblum

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto St

15- APR 14 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/13/24

17- I HEREBY CERTIFY, That I attended deceased from April 12 19 24 to April 13 19 24

that I last saw him alive on April 13 19 24

and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Hypertension, Chronic Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) W. J. Bamberger, M. D.

4/14, 1924 (Address) 210 Lexington

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Herring Run	4/14 19 24
20-UNDERTAKER,	**ADDRESS**
Jack Lewis	1439 E Balto St

Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-D 85880

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE, (No. 2401 Lauretta Ave. St. 30th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Anne Reese

(a) Residence No. #15 Georgetta St. Westminster, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Simon J. Reese

6-DATE OF BIRTH (month, day and year): Aug 30, 1840

7-AGE: 83 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9-BIRTHPLACE (city or town) (State or Country): No. Hampstead Md. Balto. Co.

PARENTS.

10-NAME OF FATHER: Unknown for name Bullison

11-BIRTHPLACE OF FATHER (city or town) (State or Country): //

12-MAIDEN NAME OF MOTHER: ? Stockdale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Co. Md.

14- (Informant) N. E. Reese
(Address) 2030 W. Saratoga St.

15-

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

APR 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr. 13-'24

17- I HEREBY CERTIFY, That I attended deceased from Apr. 8, 1924, to Apr. 13, 1924

That I last saw her alive on Apr. 12 - April 14-24

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: 12 45 A.M

Broncho-pneumonia

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Leakin Westminster — DATE OF BURIAL: 4/15 1924

20-UNDERTAKER: H Bankard & Son — ADDRESS: Westminster Md

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 85881

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Hosp ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna May Coppelman

(a) RESIDENCE No. 2111 Sassafras ST., Mt Winans WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f

4 COLOR OR RACE White

5 (Single), Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 19 1921

7 AGE Years 3 Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER John J Coppelman

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER anna Wonderd

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant (Address) John Coppelman, 2111 Sassafras st

APR 14 1924

ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/11/24, 19..., to 4/12/24, 19...,

that I last saw her alive on 4/12/24, 19...,

and that death occurred, on the date stated above, at 4:10 a m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

"3 wks" (duration) By History

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw Poth Jnr M. D.

, 19 (Address) 1629 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loundon Park Cem.

DATE OF BURIAL 4/10/1924

20 UNDERTAKER E & B Hasle

ADDRESS 1106 Mad St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85882

REGISTERED NO. 74-001 D 85882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2559 W. Fairmount (St.) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A. Klappenberg.

(a) RESIDENCE. NO. 2559 W Fairmount St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Frank Klappenberg.

6 DATE OF BIRTH (month, day, and year) June 14 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia A Herbst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs J Snyder

(Address) 2559 W Fairmount Ave

15 Filed APR 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/8 1924, to 4/13 1924, that I last saw h alive on 4/13 1924, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Mitchell M. D.

(Address) 1274 Milliam St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	Apr 15 1924
20 UNDERTAKER	ADDRESS
C A B Frank	1156 West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

85883

HEALTH DEPARTMENT—CITY OF BALTIMORE

85883

122-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Lyndhurst ave., 70 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Hall

(a) RESIDENCE No. 404 Lyndhurst ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ... mos. — ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced (or) WIFE of: Francis M Hall

6 DATE OF BIRTH (month, day, and year): Mch 8-1854

7 AGE — Years: 70 — Months: 1 — Days: 5 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): NO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Church Hill Maryland

PARENTS

10 NAME OF FATHER: John Coffage

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rebecca Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Annie Gould

(Address) 404 Lyndhurst Ave

15 APR 14 1924 ROBERT H. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1924

17

I HEREBY CERTIFY, That I attended deceased from March 23 1924 to April 13 1924

that I last saw her alive on April 12 1924,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows: Hypertrophic Arthritis Arterial Degeneration

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Age & Senility

(duration) 3 yrs 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jno C Coffage, M. D.

1924 Address 2303 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Church Hill Md — DATE OF BURIAL: Apr 14 1924

20 UNDERTAKER: Wm E. Black — ADDRESS: 927 N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—t-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85884

CERTIFICATE OF DEATH.

D 85884

101-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 820 N. Wolfe St ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Mason

(a) RESIDENCE NO. 820 ~~Imp~~ N. Wolfe St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mason

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Susan Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Robert Elliott
(Address) .....

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
APR 14 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (Rt. Lung)

.....

.....

.....

Spec.—1-10-21—M&T—1500 Bks.

D 85885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 85885

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Grafton Townsend

(a) RESIDENCE NO. 828 Rutland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Col | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) July 15 1919

7 AGE: Years 5 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Grafton Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Howlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) H Motton Lillian Townsend 828 Rutland Ave

15 Filed ..... 19 ..... ROBERT A. KRAUTER, Registrar

APR 14 1924 Burial P...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10, 19 24, to April 12, 19 24, that I last saw h... alive on April 12, 19 24, and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - 9 ds.

Streptococcus septicemia - 5 ds. ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) H. H. Wesch, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Faunal Cemetery

DATE OF BURIAL April 15, 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

CAUSE OF DEATH is very important. See instructions on back of certificates.

...CATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...'TION in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

D 85886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85886

CERTIFICATE OF DEATH.

1852

1-PLACE OF DEATH

REGISTERED NO......

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1330 Webster Street. ST. 24 WARD)

2-FULL NAME Thomas Dyer Brooks.

(a) **RESIDENCE** No. 1330 Webster Street. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Harriet Brooks.

6 DATE OF BIRTH (month, day, and year) November 15, 1842.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	4	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Tinner
(c) Name of employer .....

9 BIRTHPLACE (city or town) - (State or country) Laurel Md.

PARENTS

10 NAME OF FATHER Samuel Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Laurel Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hamilton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Laurel Md.

14 Informant Thomas J. Brooks. (son).
(Address) 1330 Webster Street.

15 Date Received APR 14 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Concussion of the brain.
Accidental fall down stairway.
shock.
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)
April 12, 1924. (Address) 1014 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Apl 14 1924

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85887

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-802 D 85887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hospital St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Robinson

(a) Residence No. 101 N. Pulaski St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. W. Robinson

6-DATE OF BIRTH (month, day and year) Feb 9/97

7-AGE. 27 yrs. 2 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Chas. Nordlander

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sophia

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Thos. W. Robinson

(Address) 101 N. Pulaski

15- APR 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 12/24

17- I HEREBY CERTIFY, That I attended deceased from Feb 13 1924 to Apr 12 1924

that I last saw h. alive on Apr 12 1924

and that death occurred, on the date stated above, at. 9 30 m.

The CAUSE OF DEATH* was as follows:

Leptomeningo-Pyocalpinx and intestinal obstruction

(Duration) yrs. 1 mos. 28 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 4/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. N. Thomas M. D.

Apr 14 1924 (Address) 1228 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	Apr 15 1924
20-UNDERTAKER, Philip Henry	ADDRESS 2016 Orleans

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85888 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 85888

Registered No.....

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3107 Fleet St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Stabler

(a) Residence No. 3107 Fleet St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah L. Stabler

6-DATE OF BIRTH (month, day and year) Oct 6/43

7-AGE, 80 yrs. 6 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... Insurance

(c) Name of employer Metropolitan Collector

9-BIRTHPLACE (city or town)..... Statlersville
(State or Country)..... Md

PARENTS.

10-NAME OF FATHER, John Stabler

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country).....

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country).....

14-

(Informant) Sarah L. Stabler

(Address) 3107 Fleet St

15-

APR 14 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apl 13/24

I HEREBY CERTIFY, That I attended deceased from April 1, 1923 to April 13 1924

that I last saw him alive on April 24 1924

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration)..... yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilson M. D.

4/14, 1924 (Address) 315 S. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Statlersville Md	7/15, 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Orleans

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Answer in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85889

CERTIFICATE OF DEATH.

129 D 85889

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 900 E. 20th St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V. Fetsch

(a) Residence No. 900 E. 20th St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed or Divorced, (Write the word.) Mar

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John M. Fetsch

6-DATE OF BIRTH (month, day and year) July 17-1853

7-AGE. 70 yrs. 8 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Robert Applegarth

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eliz. Fitzpatrick

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), not given

11- (Informant) John M. Fetsch

(Address) 900 E. 20th St

13- Filed APR 14 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 11-1924

17- I HEREBY CERTIFY, That I attended deceased from April 1 19 24 to April 11 19 24

that I last saw her alive on April 11 19 24

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. N. McElhenny, M.D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem.	April 14 1924
20-UNDERTAKER.	ADDRESS
F. A. Krauss & Son	703 Hanover St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85890

CERTIFICATE OF DEATH.

5 31 ✓ D 85890

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Horsey

(a) Residence No. 1334 E. Lexington st. St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1871

7-AGE.	If LESS than 1 day,
53 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Randan Horsey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Annie Enice

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

11- (Informant) Hospital Records

(Address) M.T.H.

15- Filed APR 14 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924 to April 11 1924

that I last saw him alive on April 11 1924,

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally M. D

4-11-, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Antrim Cemetery	Apr. 14 1924

20-UNDERTAKER Chas. F. Johnson ADDRESS 46 N. Carolina

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 1/14 D 85891

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1405 Askew Alley ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benj. Powell

(a) RESIDENCE NO. 1405 Askew Alley ST., WARD Georgia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary McGharity

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant John Powell
(Address) 1405 Askew Alley

15 Filed APR 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Gastro Indigestion

(duration) yrs. mos. ds.

(Signed) J. H. Bowen, M. D. (Coroner.)

Apr 14/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbury cemetery — DATE OF BURIAL April 14 1924

20 UNDERTAKER Edward Bryan — ADDRESS 631 orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54 D 85892

D 85892

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Newman

(a) Residence No. 1033 W. Chapel St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1900

7-AGE,	If LESS than 1 day,
24 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffeur 0 ds

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Charlestown, W. Va

PARENTS.

10-NAME OF FATHER, John Newman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Charlestown, W. Va.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Charlestown, W. Va

14- (Informant) Municipal Hospital Records

(Address)

15- APR 14 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-10-24

17- I HEREBY CERTIFY, That I attended deceased from 3-31 1924 to 4-10 1924

that I last saw h~~im~~ alive on 4-10 1924

and that death occurred, on the date stated above, at 9.20 p.m.

The CAUSE OF DEATH* was as follows:

Pellagra

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Lab

(Signed) Claude D. Bruce M. D.

4-11 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	April 15, 1924
20-UNDERTAKER. Edward Bryan	ADDRESS 1631 Orleans St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85893

CERTIFICATE OF DEATH.

129 D 85893

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 William St. ST., 24 WARD)

2-FULL NAME Fannie R.Horner

(a) RESIDENCE NO. 918 William St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXXXXXXXXXXX

6 DATE OF BIRTH (month, day, and year) Oct.29 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	60	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indianapolis Ind.

PARENTS

10 NAME OF FATHER Joseph H.Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah E.Daneker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Clara S.Horner

(Address) 918 William St.

15 Filed APR 14 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 3.7.24, 19..., to 4.12.24, 19...,

that I last saw h~~e~~live on 4.11.24, 19...,

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? clinical & chemical

(Signed) Philip B. Fowler M. D.

4.14.24, 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Apr 15 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85894 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 8 99

City of BALTIMORE: (No. 2402 E. Lafayette ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Seigler

(a) Residence No. 2402 E. Lafayette St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Catherine S. Seigler

6-DATE OF BIRTH (month, day and year) Oct. 6- 1834

7-AGE, 89 yrs. 6 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.
10-NAME OF FATHER, dontknow
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, dontknow
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Cath. Seigler
(Address) 2402 E. Lafayette ave.

15-FILED APR 14 1924 ROBERT A. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-12-24

17- I HEREBY CERTIFY, That I attended deceased from 2-26-24, 19..., to 4-12-24, 1924, that I last saw h[illegible]ive on 4-10-24, 19..., and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

..... Acute Bronchitis .....

..... (Duration) ..... yrs. 1½ mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) I. Frederick H. Herrmann M.D.

4/14/24 (Address) 2414 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pikesville, Pa. DATE OF BURIAL, 4/15th, 1924

20-UNDERTAKER, John A. Inman ADDRESS 3000 E Baltimore

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28th WARD)

2-FULL NAME Annie Leinkuhler

(a) RESIDENCE NO. Mt Hope Retreat ST., 28 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

1-001

14 D 85895

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	64	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer) " work-ho

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert A. Leinkuhler

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Weissmiller

13 BIRTHPLACE OF MOTHER (city or town) Wallenhorst (State or country) Germany

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 APR 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1912, to Apr 12th, 1924, that I last saw her alive on Apr 11th, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis Chronic Cerebral Hemorrhage

abt (duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Delusional Manic Psychosis

abt (duration) 12 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

Apr 12, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 14 1924

20 UNDERTAKER Jos. J. Merrabon — ADDRESS 1566 N. Luzerne

MATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85896

CERTIFICATE OF DEATH.

100-001

D 85896

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Mariner

(a) Residence No. 1612 Olive St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1857

7-AGE. 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ?

14- (Informant) Municipal Hospital Records

(Address)

15- APR 14 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-11-24

17- I HEREBY CERTIFY, That I attended deceased from 3-31, 1924 to 4-11, 1924

that I last saw h~~e~~ alive on 4-11, 1924

and that death occurred, on the date stated above, at 6.25 8 m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Pneumococcus Meningitis

Septicaemia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Grace M. D.

4-12, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Olivet Cemetery — DATE OF BURIAL, 4/14, 1924

20-UNDERTAKER, E. J. Fanning & Son — ADDRESS 1460 Bathurst Ave.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85897

100-001

D 85897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Dorsey

(a) Residence No. 411 Moore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1869

7-AGE, 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Hanover (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thos. Spriggs

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- ROBERT R. KRAUTER, Burial Permit Clerk.

APR 14 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-11-24

17- I HEREBY CERTIFY, That I attended deceased from 4-5, 1924, to 4-11, 1924

that I last saw her alive on 4-11, 1924

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Londonton

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Claude G. Drane M. D.

4-12 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Harlem Lawn Cem	April 15, 1924
20-UNDERTAKER,	ADDRESS
Theodore G. Hilke	113 W. Pratt

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85898

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Virginia

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 526 W. Fairmount (WARD) 19

2-FULL NAME. Lina Jenkins

(a) RESIDENCE NO. 526 W. Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Jenkins

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Durham N. C.

PARENTS

10 NAME OF FATHER Warren Ricks

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Joseph Jenkins (Address) 526 W. Fairmount

Filed APR 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1924

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1927, to April 13, 1924, that I last saw her alive on April 12, 1924, and that death occurred, on the date stated above, at 3.25 a m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency,

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Walter D. Jones & Son, M. D.

4-14-1924 (Address) 164 S. N. Mulberry.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg Va	Apr 13 1924
20 UNDERTAKER	ADDRESS
Chas W. Chase & Son	1406 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85899

CERTIFICATE OF DEATH.

X49

D 85899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Wells Gen'l Hosp ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Smith

(a) RESIDENCE NO. Meinkirk Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Hannah Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Frank Smith

(Address) Meinkirk Md.

Filed APR 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 13, 1924

that I last saw him alive on April 13, 1924

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma of the Bladder

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John A Clemmer, M. D.

, 19 (Address) South Wells Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Meinkirk Md

DATE OF BURIAL 4/16/1924

20 UNDERTAKER Leo E French

ADDRESS Lansdowne Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85900 **CERTIFICATE OF DEATH.** 129 D 85900

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Ropewalk Lane. ST., 23 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Butler. (C)

(a) **RESIDENCE NO** 122 Ropewalk Lane. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Bettie J. Butler. (C)

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis, Md

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know.

14 Informant: Bettie J. Butler. (C) wife.
(Address) 122 Ropewalk Lane

15 Filed APR 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 12, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

April 14, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: APR 14 192

20 UNDERTAKER: Commissioner of Health.

ADDRESS

TION is very important. See instructions on back of certificate.

Aurelia E Hamburg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85901

CERTIFICATE OF DEATH.

90 ✓

D 85901

Registered No. C.....

1-PLACE OF DEATH 2700 Spring Hill Ave

City of BALTIMORE (No. Mrs Aurelia E. Hamburg St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aurelia E. Hamburg

(Residence in Baltimore: No. 2700 Spring Hill Ave St., 57 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: Dec 12 1851 (Month) (Day) (Year)

7-AGE: 72 yrs. 4 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo P DeLaney

(Address) 2700 Spring Hill Ave

15-

APR 14 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 12 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Cancer of Liver

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Bowers M. D.

(Coroner.) April 13 1924 (Address) 1632 Bolton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, ~~OR REMOVAL~~. Mt Carmel DATE OF BURIAL, APR 15 1924 19...

20-UNDERTAKER, Geo W Little ADDRESS 2700 Pennsylvania Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1046 Valley St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Marie DeSales Dolan

(a) Residence No. 1046 Valley St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): April 19-1893

7-AGE: 30 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Typist
(b) General nature of industry, business, or establishment in which employed (or employer): 109
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: John Dolan

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Dollie Zimolak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant): Anne F. Burroughs
(Address) 1046 Valley St

15- Filed APR 1 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 13/1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 3, 1924, to April 13, 1924, that I last saw ~~him~~ alive on April 12, 1924, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) James M Faulon, M. D.

19- (Address) 707 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral	April 15, 1924
20-UNDERTAKER,	**ADDRESS**
H. C. Rudefind & Co	14 Greenmount Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85903

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

City of BALTIMORE: (No. Martha Nolan St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Little Sister of the Poor

(a) Residence No. Preston & Valley St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-~~Single~~, Married, Widowed, or ~~Divorced~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). France

PARENTS.

10-NAME OF FATHER, Benj. Stickel

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER, Sarah

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14-

(Informant) Sister Superior

(Address) Preston & Valley

15-

APR 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 13/24

17- I HEREBY CERTIFY, That I attended deceased from Hr. Record, 19..., to ..., 19...,

that I last saw h. Hr. ntive on Apl 7, 19 24

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Unknown (Duration) 0 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

13 . 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral	April 14, 1924

20-UNDERTAKER.	ADDRESS
C. C. Maddox	914 Druid Hill Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85904 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85904

CERTIFICATE OF DEATH.

111-60

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. J. Shea.

(a) RESIDENCE NO. 808 E. 20th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 066

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Shea

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Jennie Kating

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Record (Address)

15 Filed ....., 19 ..... Registrar

APR 14 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/24

17

I HEREBY CERTIFY, That I attended deceased from March 17th, 1924, to April 13, 1924.

that I last saw him alive on 4/12/24, 19

and that death occurred, on the date stated above, at 2.32 p.m.

The CAUSE OF DEATH* was as follows:

Ruptured Peptic Ulcer.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Subphrenic abscess

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 3/12/24

Was there an autopsy? Yes 3/14/24

What test confirmed diagnosis Clinical Findings

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Texas Md	Apr. 15 1924
20 UNDERTAKER	ADDRESS
W. C. Wiedefeld	914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85905 HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 85905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2544 Greenmount Ave ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Anna Stall

(a) RESIDENCE NO. 2544 Greenmount Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late Thomas A. Stall

6 DATE OF BIRTH (month, day, and year) April 9 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Mr. Rankin

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Miss. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. Lester A. Stall

(Address) 804 N. Kenwood Ave

15 Filed APR 14 1924 19.. Robert P. Harrison, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 9 1924 to Apr 12 1924

that I last saw her alive on Apr 12 1924

and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Loeser & Loeser, M. D.

(Address) 1438 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 16 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85906

D 85906

CERTIFICATE OF DEATH.

REGISTERED NO. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Melton Ave. Lakeland ST.; 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Florence Shipley

(Residence in Baltimore: No. Melton Ave. Lakeland, St.; 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March (Month), (Day), 1891 (Year)

7-AGE, 33 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. City.

PARENTS.

10-NAME OF FATHER, Chas. Dinkevata

11-BIRTHPLACE OF FATHER (State or Country), Scotland.

12-MAIDEN NAME OF MOTHER Ida Ringold.

13-BIRTHPLACE OF MOTHER (State or Country), Kent Island.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. J. Shipley

(Address) Lakeland Md.

15-

R 1 4 1924

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 12 (Day), 1924 (Year).

17. I HEREBY CERTIFY, That I attended deceased from June 18 1919, to April 12 1924, that I saw h[illegible] alive on April 12 1924, and that death occurred, on the date stated above, at 3 20 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency,

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 5+ yrs. mos. ds.

(Signed) H. Hammond Harden M. D.

April 12, 1924 (Address) Lakeland.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem

DATE OF BURIAL. April 15 1924

20-UNDERTAKER Fogell Finley Talbot Sayett

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85907 ✓ D 85907

CERTIFICATE OF DEATH.

10-00

D 85907

1-PLACE OF DEATH

City of BALTIMORE: (No. 524 North Fulton Ave. St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Hopper

(a) Residence No. 524 North Fulton Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 11 1868

7-AGE.	If LESS than 1 day,
55 yrs. 6 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Messenger

(b) General nature of industry, business, or establishment in which employed (or employer). Bank

(c) Name of employer Merchants Nat. Bank.

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, George Hopper

11-BIRTHPLACE OF FATHER (city or town)
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Lucretia Aler

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Md.

14- (Informant) Mrs Jennie Williams

(Address) 524 N. Fulton Ave.

15- APR 14 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 12 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 29, 1924, to Apr 12, 1924

that I last saw him alive on Apr 12, 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S K G Jones M. D.

4/14, 1924 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park Cem	Apr. 15 1924
20-UNDERTAKER.	ADDRESS.
Joseph L. Cook	1003 N. Bond St.

Burial Permit filed

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85908

1-PLACE OF DEATH

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 219 N. Paca - ST.: WARD)

2-FULL NAME Julia Langlotz

(a) RESIDENCE. No. 219 N. Paca - ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal -	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Langlotz

6 DATE OF BIRTH (month, day, and year) March 2 / 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63 —	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Howard Nack (Daughter)

(Address) 503 S Polaski St

15 [illegible] Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1924

17

I HEREBY CERTIFY, That I attended deceased from April 2d, 1924, to April 13th, 1924, that I last saw her alive on April 12th, 1924, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Not Known -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Kidney Stones (Colic)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Facts

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 16 24
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N Gay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1 4 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85909

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85909

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 W. 25th St. St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Susan Jane Gleason

(a) Residence No... 207 W. 25th St. St., 12 Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Late John J. Gleason

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. About 82 Years

If LESS than 1 day, ...hrs. or.....min.?

.....yrs.....mos.....ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Hagerstown
(State or Country), Md

PARENTS.

10-NAME OF FATHER, John D. Klein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Jane Flemming

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mr. James H. Klein

(Address) 478 Maryland Ave Washington D.C.

15- [illegible] 192[illegible]

Registrar.

APR 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 12. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 5 1924 to April 12 1924

that I last saw h[illegible] alive on April 12 1924

and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Arteriosclerosis)

Some

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration) .....yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank H. Little M. D.

April 14. 1924 Address 2435 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF [illegible], CREMATION OR [illegible]	DATE OF BURIAL.
Loudon Park Cemetery	April 15th 1924
20-UNDERTAKER.	ADDRESS
Jos Forsberg Son	217 S. Paca St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85910 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85910

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 S. Port St., 1 Ward) Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael . Marszalkiewicz

(a) Residence No. 707 S. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Maried

5a-If married, widowed, or divorced. HUSBAND of ~~XXXXX~~ Magdalena Marszalkiewicz

6-DATE OF BIRTH (month, day and year) Sep 10 1857

7-AGE. 67 yrs. 7 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Mr Milton . . Marszalkiewicz

(Address) 707 S. Port Street

15- Robert P. Harrison, Registrar.

R 1 4 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 12/24

17- I HEREBY CERTIFY, That I attended deceased from 3/31 19 24 to 4/12 19 24, that I last saw h~~im~~er alive on 4/12 19 24, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

6 hours I Hemo Pneumonia

Arteria Sclerosis

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Bronchitis Pneumonia & Heart failure

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms & symptoms

(Signed) Jay D. Ruthledge, M. D.

4/13, 1924 (Address) 1625 E 30th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Rosary	April 15, 1924
20-UNDERTAKER.	ADDRESS
John M Weber	203 Bank St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 85911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Baltimore Gen. Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Cole

(a) RESIDENCE NO. Charles Ave, near Church ST., Curtis Bay

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of Mrs. Frank Cole
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 52	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia, Pa
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. Michael Lambrawski
(Address) 21 Cypress St

15 Filed APR 14 1924, Robert F. Maffett
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/10/24, 19..., to 4/12/24, 19..., that I last saw h.[illegible] alive on 4/12/24, 19..., and that death occurred, on the date stated above, at 1010 P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P A Rothfuss, M. D.

, 19 (Address) 1629 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross C. & M. Co	April 16 1924

20 UNDERTAKER ADDRESS

John A Weber 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA... would state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85912 ✓ D 85912

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & infirmary ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Michael Totten

(a) RESIDENCE NO. 1120 St. Paul ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 9 yrs. 0 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXXXX

6 DATE OF BIRTH (month, day, and year) March 28/1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	0	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) El Paso
(State or country) Texas

PARENTS

10 NAME OF FATHER Capt. G.H.Totten

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Washington D.C

12 MAIDEN NAME OF MOTHER Jean Johnson

13 BIRTHPLACE OF MOTHER (city or town) ElPaso
(State or country) Texas

14 Informant Miss Edith Totten (Aunt)
(Address) 1120 ST. Paul St.

Filed APR 14 1924 192 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebrale Hemorrhage - Fractured Skull-(Fell while sliding banister

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Fallen, M. D.
(Coroner.)

Apr 14/24 (Address) 508 E. orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 0 yrs., 0 mos., ds. In the State 3 yrs., ? mos., ? ds.

Where was disease contracted, if not at place of death? 1120 St. Paul St

Former or usual residence 1120 St. Paul St.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL Apr 16 1924

20 UNDERTAKER STUART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85913 ✓ D 85913

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3005 Baker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... N. Albert Aldridge

(a) Residence No.... 3005 Baker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M Aldridge

6-DATE OF BIRTH (month, day and year) Feb 4 1856

7-AGE, 58 yrs. 2 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)..... B & O. R. R.
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country),

PARENTS:
10-NAME OF FATHER, John Aldridge
11-BIRTHPLACE OF FATHER (city or town)..... Maine
(State or Country),
12-MAIDEN NAME OF MOTHER, Louise Posey
13-BIRTHPLACE OF MOTHER (city or town)..... Md.
(State or Country),

11- (Informant) Ida M. Aldridge
(Address) 3005 Baker St

13. Robert P. Harrison, 192
Registrar.

R 1 4 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 14-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 31, 1924, to April 14 1924, that I last saw him alive on April 13 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Heart Block

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) F. McLaughlin M. D

(Address) 526 N Carrollton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 16 1924
20-UNDERTAKER	ADDRESS
H. E. Lackner Sons	Balto Md

Exact statement of OCCUPATION is very important. Physicians are earnestly requested to fill out all blanks in plain terms, so that it may be properly classified. Read instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85914

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Buck's Lane and Leona Ave St., 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie B Tinley

(a) Residence No. Buck's Lane and Leona Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ernest E. Tinley

6-DATE OF BIRTH (month, day and year): Sept 14 1865

7-AGE, 58 yrs. 6 mos. 29 ds. If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Penna

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-

(Informant) Ernest Tinley

(Address) Buck's Lane Leona

APR 14 1924

Robert P. Harrison, M.D.
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr 12-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1923, to April 12th, 1924

that I last saw h.. alive on April 12th, 1924,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis

(Duration) 5 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Herbert F. Stillman M. D

, 19 (Address) 6 E Biddle St.

*State the **Disease Causing Death**; or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	April 15 1924
20-UNDERTAKER: Wm. G. Lickney & Sons	ADDRESS: North Ave

Should be carefully supplied. Note—Words to be written in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D 85915

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 N. North Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Nichols

(a) Residence No. 810 N. North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, Woman

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John B Nichols

6-DATE OF BIRTH (month, day and year) Oct 28 1855

7-AGE 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER Ignatius H Norris

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Hannah Foxwell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14-(Informant) Benj J Norris

(Address) 1952 Lindens Ave

15-

Filed..... Robert P. Harrison..... Registrar.

R 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 13-24

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1923, to April 13, 1924, that I last saw h[illegible] alive on April 6, 1924, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Ulceration Colitis.

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry D. McCarty M. D

4-14, 1924 (Address) 817 W Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Arnolds Sta A & C Md. DATE OF BURIAL. April 15 1924

20-UNDERTAKER. John A Mitchell ADDRESS 1201 W Fayette St

Should be carefully supplied. Age when 1 year or less, in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very Important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85916

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2356 Eutaw Place St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. Buson

(a) Residence No. 2356 Eutaw Place St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mahlon A Buson

6-DATE OF BIRTH (month, day and year)

7-AGE. 81 yrs. 7 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..a..a..Co..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Pezin Hammond

11-BIRTHPLACE OF FATHER (city or town)....a..a..Co (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ann C. Thomas

13-BIRTHPLACE OF MOTHER (city or town)....a..a..Co (State or Country), Md

14- (Informant) Margaret E. Mitchell

(Address) 2356 Eutaw Place

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

R 1 4 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 13 - 24

17- I HEREBY CERTIFY, That I attended deceased from Aug 3, 1923, to Apr 13, 1924 that I last saw her alive on Apr 13, 1924 and that death occurred, on the date stated above, at 7.33 P. M.

The CAUSE OF DEATH* was as follows:

acute Bronchitis r
Cardiac Dilatation.

(Duration) ✓ yr. ✓ mos. 6 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease and arteriosclerosis

(Duration) over 8 mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry E. Hale M. D.

Apr 14 1924 (Address) 1203 W. Fayette St,

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. David Ridge Cem — DATE OF BURIAL. Apr. 16, 1924

20-UNDERTAKER. John Oursler & Co — ADDRESS 120 W. Fayette St.

Should be carefully supplied. Be sure to have it properly classified. Exact statement of OCCUPATION is very important. See instructions in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 85917

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D 85917

REGISTERED NO. C .....

1-PLACE OF DEATH 15 E Preston St.

CITY OF BALTIMORE (No. Baltimore, Md. 17 ST. ..... WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Eichelberger Boone

(Residence in Baltimore: No. 323 E. 20th St. St.; 1 yrs. 3 mos. 28 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, ~~MARRIED~~ ~~WIDOWED~~ OR ~~DIVORCED~~ (Write the word): Single

6-DATE OF BIRTH: Feb. 11-Th (Month), 1858 (Year)

7-AGE: 66 yrs. 2 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Frederick, Md.

PARENTS

10-NAME OF FATHER: Jermingham Boone

11-BIRTHPLACE OF FATHER (State or country): Penna.

12-MAIDEN NAME OF MOTHER: Margaret Eichelberger

13-BIRTHPLACE OF MOTHER (State or country): Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. E. Stonebreaker

(Address) 328 E. 20th St. City

15- APR 14 1924, 191 .....

Robert P. Harrison, REGISTRAR

~~Burial Permit Clerk~~.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 13 (Day), 1924 (Year)

I HEREBY CERTIFY, That I attended deceased from June 19, 1919, to Apr 13, 1924, that I saw her alive on Apr 13, 1924, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 4 yrs. ..... mos. ..... ds

Contributory (SECONDARY) Mitral Regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. McLean M. D.

Apr. 13, 1924 (Address) 1203 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Frederick Md — DATE OF BURIAL: April 19, 1924

20-UNDERTAKER: John C. Mitchell — ADDRESS: 1201 W Fayette

B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 85918

D 85918

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Clarkson ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose F Greif

(a) RESIDENCE NO. 1629 Clarkson ST., 15 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F Greif

6 DATE OF BIRTH (month, day, and year) 4/26 - 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frederick Otto

11 BIRTHPLACE OF FATHER (city or town) Do Not Know.
(State or country)

12 MAIDEN NAME OF MOTHER Laura Donat

13 BIRTHPLACE OF MOTHER (city or town) Prus.
(State or country)

14 Informant Mrs. Greif
(Address) 1629 Clarkson St.

15 Robert P. Harrison, Registrar

R 1 4 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1924

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1924, to April 12, 1924.

that I last saw her alive on April 12, 1924

and that death occurred, on the date stated above, at 1-00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Epharetism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. P. Campbell M. D.

April 14 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	4/15/1924
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1318 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85919

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28 WARD)

2-FULL NAME Edward Reicher

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Not Known

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt	36	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Franklin Co (State or country) Pa

PARENTS

10 NAME OF FATHER L. Reicher

11 BIRTHPLACE OF FATHER (city or town) Franklin Co (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) (?)

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md

15 APR 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th, 1922 to Apr 14 1924, that I last saw h alive on Apr 14. 1924, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Disease of Heart (Mitral Insufficiency)

Complicated by - abt (duration) 0 yrs. 3 mos 0 ds.

Nephritis

CONTRIBUTORY (Secondary) Dementia Praecox

abt (duration) 17 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Chambersburg Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chambersburg Pa — DATE OF BURIAL April 17 1924

20 UNDERTAKER W M Routson — ADDRESS 2238 N Mich

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85920

CERTIFICATE OF DEATH.

100-001 D 85920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 S. Paca St. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Julian Dubowski.

(a) RESIDENCE No. 427 S. Paca St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Julian Dubowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Agata Goberys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania.

14 Informant Agata Dubowski (mother)

(Address) 427 S. Paca St.

Filed APR 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from February 26, 1924, to April 13, 1924,

that I last saw him alive on April 8, 1924,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

primary.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

4/13 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 16, 1924
20 UNDERTAKER	ADDRESS
John Greblauckas J.G.	425 S Paca St

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85921

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital, 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Thomas

(a) Residence No. 227 S. Green st. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 070

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

11- (Informant) Hospital Records

(Address) M.T.H.

APR 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4-13-24

17- I HEREBY CERTIFY, That I attended deceased from April 12 1924 to April 13 1924

that I last saw h. or alive on April 12 1924

and that death occurred, on the date stated above, at 6.55 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy, Sputum

(Signed) L. A. Lally M. D

4-14-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
ST. STANISLAUS	April 15, 1924
20-UNDERTAKER.	ADDRESS
John Greblauckas	425 S Pace St.

J.G.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS filling state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

85922

CERTIFICATE OF DEATH.

3/ D 85922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 Lewis ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lelia Jacobs

(a) RESIDENCE NO. 407 Lewis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (or) WIFE of Randolph Jacobs

6 DATE OF BIRTH (month, day, and year) May ?, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	11	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dillon S.C.

PARENTS

10 NAME OF FATHER Willie Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Jane Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Randolph Jacobs Husband (Address) 407 Lewis

15 APR 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I attended deceased from April . 1924. to April 11 . 1924.

that I last saw h alive on April 10 . 1924,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Tuberculous Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) R J Gosh, M. D.

4/11. 1924 (Address) 14 Eye & Throat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dillion. S. Carolina

DATE OF BURIAL April 19 24

20 UNDERTAKER Milton Davis

ADDRESS 24 319 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85923

74 D 85923

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) 6.48 P.m.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4929 Denmore ave ST., 27 WARD)

2-FULL NAME David McG. Shipley

(a) RESIDENCE No. 4927 Denmore ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Fanny G. Shipley

6 DATE OF BIRTH (month, day, and year) Nov 5 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) — 0 — 6

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Baltimore
(State or country) maryland

PARENTS

10 NAME OF FATHER Joseph P. Shipley

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Georgianna Childs

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Maryland

14 Informant David McG Shipley Jr
(Address) 4927 Denmore Ave

15 Filed APR 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1924

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to April 12, 1924,

that I last saw h alive on April 12, 1924,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

Uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Complete Hemiplegia

Aug 4 (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) L B Vermont M. D.

4.14.1924 (Address) 3547 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL April 15 1924

20 UNDERTAKER John B. Spence — ADDRESS 1325 N. Caroline St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very impcrtant. See instructions on back of certificates.

Srec—12-23-21—E.B.R.S.—400 Eks.

D 85924 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 85924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No 2300 Whittier ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Levin

(a) Residence No. 2300 Whittier ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	White	M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annabelle Levin

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
71 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer) 80

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Asher Levin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Goldie Rosel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Levin's

(Address) 1439 E. Baltimore

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

APR 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/14/24

17- I HEREBY CERTIFY, That I attended deceased from April 7, 1924 to April 14, 1924

that I last saw him alive on April 14, 1924

and that death occurred, on the date stated above, at 6.24 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis Uremia

Sclerosis

3 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

7 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) M. D.

4/15, 1924 (Address) 310 Aisquith

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Sanitarium ave	4/15, 1924
20-UNDERTAKER.	ADDRESS
Jack Levin's 1439	E Balto St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85925

52

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ~~811 Ostend St~~ ST., 1 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Lister

(a) RESIDENCE NO. 811 Ostend St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, ~~Married, Widowed or Divorced, (write the word)~~: Single

5a If married, widowed, or divorced ~~HUSBAND~~ (or) ~~WIFE~~ of: Single

6 DATE OF BIRTH (month, day, and year): July 4 1887

7 AGE: Years 36 Months 9 Days 8

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bruce Hogg County

PARENTS

10 NAME OF FATHER: John Fosher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn George County

12 MAIDEN NAME OF MOTHER: Hannah Corliss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penn George County

14 Informant: Mrs John Fosher

(Address): 811 Ostend St

APR 15 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4|12|24 19

17 I HEREBY CERTIFY, That I attended deceased from 4|10|24, 19..., to 4|12|24. 19...,

that I last saw her alive on 4|12|24, 19...,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio-Vascular disease, Mitral & Aortic Insufficiency.

(duration) 20? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Subacute Bacterial Endocarditis (duration) ..... yrs. 4-? mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Wm Thom Jr. ....., M. D.

....., 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery

DATE OF BURIAL: April 15 1924

UNDERTAKER: Jno. G. Koerber & Co

ADDRESS: 410 W. Conway St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85926

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1335 Division ST. 17 WARD

2-FULL NAME 1335 Division Robert Jackson

(a) RESIDENCE NO. 1335 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Jno Jackson
(Address) 1335 Division St

15 Filed APR 5 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/18/, 1924, to 4/13/, 1924, that I last saw h[illegible] alive on 4/13/, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of Scalp

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno C Robinson M. D.

19 24 (Address) 1525 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL April 15 19 24

20 UNDERTAKER Jno Gerst Hooper 406 W Conway St — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2616 E Madison St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Seibel

(a) Residence No. 2615 E Madison St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Walter

6-DATE OF BIRTH (month, day and year) Oct 5-1898

7-AGE. 25 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 637

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Charles Werner

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Emma Reisch

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Austria

14- (Informant) Walter Seibel

(Address) 2615 E Madison St

15- Filed APR 15 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 13/24

17- I HEREBY CERTIFY, That I attended deceased from April 4 1923 to April 13 1924

that I last saw h... alive on April 17 1924

and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Sputum

(Signed) Wm. L. Gerry M. D.

19 (Address) 6 W Mt. Royal Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Ft. Lyon Colo	Apl 16 1924
20-UNDERTAKER, Frank Evershon	ADDRESS 1906 Gilmor

Should be carefully supplied. Age should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 85928

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D 85928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 W. Hoffman ST. 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Chase.

(a) RESIDENCE. NO. 644 W. Hoffman ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur E. Chase.

6 DATE OF BIRTH (month, day, and year) Aug 4 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress in home

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Calvert Co (State or country) Maryland

PARENTS

10 NAME OF FATHER David C Highton

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Gemima Hyles

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Maryland

11 Informant Gertrude Kennard

(Address) 644 W Hoffman St

15 Filed . 19

APR 15 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1924

17 I HEREBY CERTIFY, That I attended deceased from February 26 1924, to April 12, 1924, that I last saw her alive on Apr 10 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis (Chronic)

(duration One yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1154 Shields Alley

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings only

(Signed) Lowell Sapp, M. D.

19 (Address) 2937 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Apr 15 1924

20 UNDERTAKER Jesse Redden

ADDRESS 432 Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85929 CERTIFICATE OF DEATH. 161-001 D 85929

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 916 Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Mr & Mrs Geo Meinke

(a) RESIDENCE NO. 916 Hanover ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Meinke

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Bloyer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Geo Meinke
(Address) 916 Hanover St.

15 Filed APR 15 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1924

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924 to April 13, 1924

that I last saw him alive on April 13, 1924

and that death occurred, on the date stated above, at 1-10 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ephauten

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R.R. Campbell M. D.

APR 10 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER Commissioner Health.	ADDRESS APR 14 1924

For Wm. F. WOODALL,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Maudich

17 041

D 85930

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 ✓ D 85930

1-PLACE OF DEATH

CITY OF BALTIMORE (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Haza Maudich

(a) RESIDENCE NO. 1407 Fonanica ST., WARD

(Usual place of abode) Charleston, W. Va.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Louis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Servia

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Servia

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 15 1924 ROBERT R. KRAUSER, Registrar Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 24, 1924, to April 7, 1924, that I last saw him alive on April 7, 1924, and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma - Trachea. Bronchus, right. Mediastinum. Lymph's. Trachea Stenosis Obstruction Superior Vena Cava.

(duration) yrs. 9 mos da.

CONTRIBUTORY (Secondary) Hemorrhage - tracheal. - Origin Unknown, probably tuberculosis Lymph. Nodes (duration) yrs. mos. 5 min.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. P. Hannon, M. D.

4/7, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 8th 1924

20 UNDERTAKER A. Jones — ADDRESS 1118 Gilmor

AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Youngstroys. 25th & Barclay

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85931

D 85931

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 627 East 30th St. 9 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Suter

(a) Residence No. 627 East 30th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. A. Suter

6-DATE OF BIRTH (month, day and year) Dec 8. 1841

7-AGE, 81 yrs. 4 mos. 6 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER Moses Kelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Mary C Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14- (Informant) Minnie V. Buckingham

(Address) 627 E. 30th St.

15- Filed APR 15 1924 19 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 14. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 9th 19 24 to April 14th 19 24

that I last saw him alive on April 14th 19 24

and that death occurred, on the date stated above, at 6 10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jno W. Ettinger 1070 116 M. D.

4/15, 19 24 (Address) 401 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
London	Apr 17, 1924
20-UNDERTAKER,	ADDRESS
Edw Cook	501 E 25th St

Should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should be specified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Schooler

Spec.—1-10-21—M&T—1500 Bks.

D 85932 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85932

80

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Adelaide Schooler

(a) RESIDENCE NO. 602 W. North Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —— 1922

6 DATE OF BIRTH (month, day, and year) April 3-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	2		11	

8 OCCUPATION OF DECEASED

(a) Trade profession or particular kind of work ——— Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Clyde Schooler

11 BIRTHPLACE OF FATHER (city or town) Julian
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Margaret Howell

13 BIRTHPLACE OF MOTHER (city or town) Ashville
(State or country) N. C.

14 Informant Clyde Schooler
(Address) 602 W. North Ave

15 Filed APR 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1924

17 I HEREBY CERTIFY, That I attended deceased from March 24 1924 to April 14. 1924

that I last saw h. alive on April 14. 1924

and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Convulsions — cause undetermined probably Cerebral Hemorrhage

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis?

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakeland	April 16, 1924
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101-001 D 85933

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospt. ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Edith Woods

(a) RESIDENCE NO. 3018 Mathews St ST., WARD 9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
female	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Edward Woods

6 DATE OF BIRTH (month, day, and year) Nov 23 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Oscar N. Vick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Ruble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Edward Woods
(Address) 3015 Mathews St

15 Filed APR 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-24

17 I HEREBY CERTIFY, That I attended deceased from 4-11-24, 19..., to 4-15-24, 19...,

that I last saw h~~e~~r alive on 4-15-24, 19...,

and that death occurred, on the date stated above, at 4 ~~P~~ a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dil 3 mo

Pulmonary Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Acker Phillips, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roanoke, Va. DATE OF BURIAL Apr 16, 1924

20 UNDERTAKER Wm Cook & Son Embalmers ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Whiting

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85934

CERTIFICATE OF DEATH.

5T D 85934

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 727 Chase ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Whiting

(a) RESIDENCE NO. 727 Chase ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam. Whiting

6 DATE OF BIRTH (month, day, and year) 1/10/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) do

PARENTS

10 NAME OF FATHER John Dodrupsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Charlotte Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Whiting

(Address) 1818 Druid Hill Ave

Filed APR 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1924, to April 13th 1924

that I last saw h alive on April 12th, 1924

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Probably from

Cause Chronic ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 727 Chase St. 19 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Va	4-15 1924
20 UNDERTAKER Daniel Carlon	ADDRESS 916 Pine.

N. B. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85935

CERTIFICATE OF DEATH.

90 ✓

D 85935

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Jackson ST.: 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gertrude M. Hoogeboom

(Residence in Baltimore: No. 1827 Jackson St.; 23 yrs., mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, wh.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar. 31, 1901
(Month) (Day) (Year)

7-AGE, 23 yrs. 12 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER. Rudolph Quandt

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Clara Bingel

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rudolph Quandt

(Address) 1827 Jackson St

15- Filed APR 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) — 10 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 3—10—1924, to 4—10—1924, that I saw h M alive on 4—10—1924, and that death occurred, on the date stated above, at 12.10 m.

The CAUSE OF DEATH* was as follows:

Hypertrophied heart, Arteriosclerosis, insufficiency decompensated

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 1 mos. 10 ds.

(Signed) S. Emmans M. D.

4—17—, 1924 (Address) 100 S. London

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. April 15, 1924

20-UNDERTAKER Margaret L. Hyman

ADDRESS 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Hammond

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85936

CERTIFICATE OF DEATH.

129 D 85936

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 415 E. Eutaw ST., 24 WARD)

2-FULL NAME Robert Theodore Hammond

(a) RESIDENCE NO. 415 E. Eutaw ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgeanna Hammond

6 DATE OF BIRTH (month, day, and year) Jan 2, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or .... min.
	66	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Wm. Stanger (Daughter)

(Address) 415 E. Eutaw

15 Filed APR 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 19 24

17 I HEREBY CERTIFY, That I attended deceased from April 7, 19 24 to April 14, 19 24

that I last saw h.. alive on April 12, 19 24

and that death occurred, on the date stated above, at 12 1 m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. E. Stevens M. D.

415 E. 19 24 (Address) 1 E. Randolph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL April 17 1924

20 UNDERTAKER Margaret G. Flynn ADDRESS 1722 Light

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

D 85937

Sambley

HEALTH DEPARTMENT—CITY OF BALTIMORE

44

D 85937

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1041 Argyle Av ST. 17 WARD)

2-FULL NAME Joseph Sambley

(a) RESIDENCE NO. 1041 Argyle Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. — ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lonia Sambley

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Private Waiter

(c) Name of employer Mr McComas, Portland Pl

9 BIRTHPLACE (city or town) (State or country) Annapolis Maryland

PARENTS

10 NAME OF FATHER John Sambley

11 BIRTHPLACE OF FATHER (city or town) (State or country) aaCo Md

12 MAIDEN NAME OF MOTHER Susan Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) aaCo Md

14 Informant George Sambley
(Address) Annapolis Md

15 APR 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1924

17 I HEREBY CERTIFY, That I attended deceased from November 18, 1923, to April 13, 1924,

that I last saw him alive on April 11, 1924,

and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of liver

(duration) — yrs. 11 mos — ds.

CONTRIBUTORY (Secondary) Cirrhosis of Stomach

Oedema (duration) — yrs. 11 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Course

(Signed) Edward Eichelberger M. D.

April 14, 1924 (Address) 1339 W. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Best Gate Anne Arundel Co	April 16 1924
20 UNDERTAKER John H Owens	ADDRESS 538 Dolphin St

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 85938

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Tillman

(a) Residence No. 1926 Etting Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colred	Widowed.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
67 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Washington (State or Country), D.C.

PARENTS.

10-NAME OF FATHER, Richard Tillman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Delia

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland.

14- (Informant) James Forest

(Address) 1821 Dawson

15- Filed APR 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/13/24

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1924, to April 13, 1924, that I last saw him alive on April 13, 1924, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. H. Fuller M. D.

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem.	Apr. 17th, 1924
20-UNDERTAKER.	ADDRESS
Jos. Heun & Son	708 Eutaw St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85939

CERTIFICATE OF DEATH.

101-001 ✓ D 85939

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette W Payson ST., 20 WARD)

2-FULL NAME Miss Angela H Albrecht

(a) RESIDENCE NO. 2337 Frederick Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30. 1876

7 AGE — Years 47 | Months 10 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Nagy-Becskerek
(State or country) Hungary

PARENTS

10 NAME OF FATHER Adalbert Albrecht

11 BIRTHPLACE OF FATHER (city or town) Lubotorba
(State or country) Galicia

12 MAIDEN NAME OF MOTHER Jarity

13 BIRTHPLACE OF MOTHER (city or town) Nagy-Becskerek
(State or country) Hungary

14 Informant Ernst Albrecht
(Address) 2337 Frederick Ave

15 Filed ..... 19 .....

APR 15 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 13, 1924, to Apr. 14, 1924.

that I last saw h.r alive on Apr. 14, 1924,

and that death occurred, on the date stated above, at 10:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H Albrecht M. D.

4/14/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem | DATE OF BURIAL 4/16/24

20 UNDERTAKER Geye & Tinley | ADDRESS Fulton & Fayette

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85940

CERTIFICATE OF DEATH.

1-001

167 D 85940

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 215 S 13 ond. ST. 3 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theador Abel.

(Residence in Baltimore: No. 215 S Bond. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR ~~DIVORCED~~. (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1- (Month) (Day) (Year)

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or mins.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Balto.

PARENTS.

10-NAME OF FATHER. John Abell

11-BIRTHPLACE OF FATHER (State or Country). Balto.

12-MAIDEN NAME OF MOTHER. Unknown.

13-BIRTHPLACE OF MOTHER (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Catherine Abel

(Address) 215 S Bond St.

15- APR 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 13, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Gas Ill.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) Geo Clinton Blades M. D. (Coroner.)

4/15/24 191... (Address) 143 W Lanvale

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Holy Redeemer

DATE OF BURIAL, Apr. 14 1924

20-UNDERTAKER Kendall & Lippel

ADDRESS 37 S Carey

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85941

CERTIFICATE OF DEATH.

101-001 ✓

D 85941 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Evans

(a) Residence No. 817 S. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6-DATE OF BIRTH (month, day and year) 1870

7-AGE.	If LESS than 1 day,
54 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer). 806

(c) Name of employer.

9-BIRTHPLACE (city or town) New Zealand (State or Country),

PARENTS.

10-NAME OF FATHER, Charles Evans

11-BIRTHPLACE OF FATHER (city or town) Wales (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Quick

13-BIRTHPLACE OF MOTHER (city or town) Wales (State or Country).

14- (Informant) Municipal Hospital Records

(Address)

15- Filed Robert P. Harris Registrar.

R 1 5 1924

Burial Permit Sent.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-13-24

17- I HEREBY CERTIFY, That I attended deceased from 4-11, 1924, to 4-13, 1924, that I last saw him alive on 4-13, 1924, and that death occurred, on the date stated above, at 11.40 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pneumococcus meningitis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? ~~Lab~~ + Autopsy

(Signed) Claude A. Dace M. D.

4-17, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Carmel	Apr. 16, 1924
20-UNDERTAKER	ADDRESS
Wm. Cook	502 E. Monument

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 85942 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 2019 Mc Henry St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Fenner Webster

(a) Residence No. 2019 Mc Henry St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 14th 24

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 11 hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country)

PARENTS.

10-NAME OF FATHER, Geo. F. Webster

11-BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or Country)

12-MAIDEN NAME OF MOTHER, Emma E. Brown

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or Country)

14- (Informant) Geo. F. Webster Sr
(Address) 2019 Mc Henry St

15- Robert F. Harrison,
Filed ....., 192.....
Registrar.
Burial Permit Clerk.

APR 15 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 15/24

17- I HEREBY CERTIFY, That I attended deceased from April 14 1924 to April 15 1924

that I last saw h—alive on April 14 1924

and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

Premature delivery of 8th month —

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? NW Date of .....

Was there an autopsy? NW

What test confirmed diagnosis? —

(Signed) Howard W Jones M. D.

4-15, 1924 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	April 15 1924

20-UNDERTAKER	ADDRESS
F. B. Nugent	2256 Fulton Ave

EXACTLY. PHYSICIANS should state CAU... DEATH. Exact statement of OCCUPATION is ve... Impor... should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85943

CERTIFICATE OF DEATH.

90 D 85943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2411 E. Monument St. ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Herold.

(a) RESIDENCE NO. 2411 E. Monument ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Herold.

6 DATE OF BIRTH (month, day, and year) July 6 - 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Mathew Herold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Stauff.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Hannah Herold.
(Address) 2411 E. Monument St.

APR 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1924, to 4-13, 1924 that I last saw h[illegible]ve on 4-12, 1924 and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
Cardiac asthma

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings.

(Signed) J. Fred Rogers M. D.

4-14-1924 (Address) 6100 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	April 16 1924
20 UNDERTAKER Lilly & Zeile	ADDRESS 403 S. Mo[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85944

CERTIFICATE OF DEATH.

D 85944

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD) 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Columbus Broad

(a) RESIDENCE NO. 349 Wilcox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant
(Address)

APR 15 1924
Filed , 192 Robert F. Harrison, Registrar

THE MORGUE, 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held nn Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

De La Mes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo Clinton Bladen M. D.
(Coroner.)

4/15/24, 192 (Address) 153 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: APR 15 1924

20 UNDERTAKER: Commissioner of Health.

ADDRESS

*CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 85945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 85945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2272 S. Clinton ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Gunning (Gunning)

(a) RESIDENCE No. 423 S. Date ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	—			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) #40
(c) Name of employer

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant
(Address)

15
Filed APR 14 1924 192 Robert P. Harrison,
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo Clinton Yates, M. D.
(Coroner.)

April 15th, 192 (Address) 43 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	APR 15 1924 192
20 UNDERTAKER	ADDRESS

Commissioner of Health.

For Wm. R. Russell

FILED APR 14 1924

THE MORGUE

TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85946

CERTIFICATE OF DEATH.

90

D 85946

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hospital ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ina Brown

(a) RESIDENCE NO 11 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 —			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) —
(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant.....
(Address)

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Jr Bladen M. D.
(Coroner)

4/5/24, 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1/0

Robert F. Harrison,

THE MORGUE

UNIVERSITY OF MARYLAND

Commissioner Health.

Spec.—1-10-21—M&T—1500 Bks.

D 85947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85947

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene Sts. WARD 25)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul E Skipper

(a) RESIDENCE NO. 219 Potapsco St ST., 25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22nd 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Evan E. Skipper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Catherine Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Community Hospital Record

(Address) Lombard & Greene Sts

15 Robert F. Harrison, Registrar

Nurse ... Staff

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to April 14, 1924

that I last saw him alive on April 14, 1924,

and that death occurred, on the date stated above, at 12 15 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operated Thoracotomy for Empyema (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of Apr 5/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sputum Sputum

(Signed) W Wallace Wallace M. D.

, 19 (Address) Community Hospital Lombard & Greene Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Apr 16 1924
20 UNDERTAKER E Schuman Son	ADDRESS 1037 Hanover

APR 15 1924

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85948

CERTIFICATE OF DEATH.

31

D 85948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hosp WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Edward Lee

(a) RESIDENCE No. 1022 Rutland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Lee

6 DATE OF BIRTH (month, day, and year) Dec 8, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tar Roofing Job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Edward Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Franz

14 Informant Mrs Sophia Kaufmann

(Address) 1022 Rutland Ave

15 Filed ..... 19 Robert P. Harrison, Registrar

Burial Permit Clerk

PR 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13 1924

17

I HEREBY CERTIFY, That I attended deceased from 4-6 1924, to 4-13 1924.

that I last saw him alive on 4-13 1924.

and that death occurred, on the date stated above, at 9 11 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of Brain

(duration) yrs. ? mos about ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4-14-24

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) Jno A Hampshire, M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross. Brooklyn

DATE OF BURIAL April 16 1924

20 UNDERTAKER William G Schaeffer

ADDRESS 1816 Monument

E should be stated EXACTLY. PHYSICIANS sho
it may be properly classified. Exact statement of OC
on back of certificates.

mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on ba

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85949

CERTIFICATE OF DEATH.

D 85949

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. University Hospital ST., ... WARD)

2-FULL NAME Robert Harrison

(a) RESIDENCE NO. Oella Rd ST., ... WARD Oella Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Mrs Effie Harrison

6 DATE OF BIRTH (month, day, and year) Unknown 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Card Stripper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. J. Pinkey & Sons St Louis Missouri

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant C. E. Delosier

(Address) Ellicott City

15 APR 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-13 1924 to 4-15 1924

that I last saw him alive on 4-15 1924

and that death occurred, on the date stated above, at 12:15 p m.

The CAUSE OF DEATH* was as follows:

(1) Varicose Ulcer & Streptococci infection - septic

(2) Cellulitis

(3) Lymphangitis (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of 4-14-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) C. E. Delosier M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. John's Cem	Apr. 16 1924
20 UNDERTAKER Edelen Sons	ADDRESS Ellicott City

R 15 1924

I. B. WHITE PRINTING CO., MANUFACTURERS, BALTIMORE. MD.

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85950

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 85950

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1711 W Fayette ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia E Murray

(a) RESIDENCE NO. 1917 W Fayette ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos H Murray

6 DATE OF BIRTH (month, day, and year) Dec 1 1851

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Bowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ralph Murray

(Address) 1911 W Fayette St

15 Robert P. Harrison, Registrar

Burial Permit Clerk

R 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar 29, 1924, to Apl 14, 1924,

that I last saw her alive on Apl 14, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Cold

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Smith, M. D.

Apl 15, 1924 (Address) 109 St. Lee Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	4/16 24
20 UNDERTAKER	ADDRESS
Geo E Farley	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Lalia Lang)

D 85951 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ D 85951

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lalia Lang

(a) RESIDENCE NO. 600 S 15th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15th 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	9	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Arthur Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Emma Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mich

14 JOHNS HOPKINS HOSPITAL

Informant

(Address)

15 Filed APR 15 1924, 19.... Robert P. Harris

Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1924

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1924, to April 13, 1924, that I last saw her alive on April 13, 1924, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

Empyema.

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 4/11/24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Findings

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn.	April 15 1924
20 UNDERTAKER	ADDRESS
Leo G. Cook	North & Hartford Ave

R. 8.—WRITE PLAINLY, WITH PEN AND INK. THIS BLANK must be filled in PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85952 ✓ 159-002 D 85952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Rutland ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Myrtle R. Smith

(a) RESIDENCE NO. Rock Hall, Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hall
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. Smith

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Mary Legg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bacco, Md

14 Informant Mary Smith
(Address) Rock Hall, Md

15 Filed ..... 192 ..... Robert F. Harrison, Registrar

PR 15 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14/ 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congental Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 9 mos. 9 ds.

(Signed) J. S. H. Allen, M. D. (Coroner.)

April 15 1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL April 17 1924

20 UNDERTAKER Wm. Cook — ADDRESS 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85953

CERTIFICATE OF DEATH.

D 85953

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2020 W. Washington St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances I. Galick

(a) Residence No. 2020 W. Washington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John T. [illegible]

6-DATE OF BIRTH (month, day and year) Dec 1867

7-AGE. 56 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. W. McConas

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER, Emma J. Dill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Mrs. R. W. Grayson 2020 W. Wash.

(Address)

15-

Filed PR 15 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 21st 1924 to April 19..

that I last saw h[illegible] alive on Apr 14 1924

and that death occurred, on the date stated above, at 6.35 a m.

The CAUSE OF DEATH* was as follows:

Tuberculer Peritonitis

(Duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary) Sarcoma of Uterus

(Duration) yrs. 3 mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mch 28th 24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alexander Thom M. D.

, 19 (Address) 2020 W. Wash.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	April 16 1924

20-UNDERTAKER	ADDRESS
Wm Cook	502 E. Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85954

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 Linden Ave 11 St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ulysses N. McElroy

(a) Residence No. 1008 Linden St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 58 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman 62

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER John M. Elroy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER Sarah Kirkpatrick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penna

14-

(Informant) F. S. Bowman

(Address) 15 W. 29th St

15-

FILED ..... 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 15-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922 to April 15, 1924, that I last saw him alive on April 8, 1924, and that death occurred, on the date stated above, at 4.10 A.M.

The CAUSE OF DEATH* was as follows:

Cardio vascular hypertension

(Diabetes)

(Duration) many yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy (Hemorrhage)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Geo. M. Fuller M. D.

(Address) April 15 1924 24-36 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Balto

DATE OF BURIAL, 4-17, 1924

20-UNDERTAKER, Wm Cook

ADDRESS 502 C Ave

Burial Permit Given

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 15 1924

Spec.—1-10-21—M&T—1500 Bks.

D 85955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85955

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 414 St Mary ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Washington

(a) RESIDENCE NO. 414 St Mary ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Baltimore yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb 22. 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or .... min.
85	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer Mrs Brewer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Ruth Sprow (Address) Govans Md

15 Filed APR 15 1924 Robert P. Harrison, Registrar

Mabel Perrill Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13. 1924

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1924, to April 13, 1924, that I last saw ~~him~~ her alive on April 13 1924, and that death occurred, on the date stated above, at 4:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

4/15. 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Belmont Cem.

DATE OF BURIAL 4/16 1924

20 UNDERTAKER Samuel Hawley

ADDRESS 578 N Bradford

FILL IN PENCIL, WITH CARBON INK. Every question should be carefully answered. If any question does not apply, write "none." NAME should be stated EXACTLY. AGE should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 15 1324

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85956

CERTIFICATE OF DEATH.

90 D 85956

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 McCulloh ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Fisher

(a) RESIDENCE NO. 1606 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct 15, 1885

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
38	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Thomas Fisher

(Address) 756 Hanover St

15 Robert P. Harrison, Registrar

APR 15 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 15th 1924 to April 15th 1924

that I last saw h[illegible] alive on April 15th 1924

and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy & Cerebral Hemorrhage

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

4/15, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	4/16 1924
20 UNDERTAKER Samuel J. Wensley	ADDRESS 1 Biddle St

BE WRITTEN, WITH UNFADING INK. EVERY ... should be stated EXACTLY. PHYSICIAN ... should be ... that it may be properly classified. Exact statement of OCCUPA... See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 85957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 767 W. Mulberry ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw Carter

(a) RESIDENCE NO 767 W Mulberry st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Carter

6 DATE OF BIRTH (month, day, and year) [illegible] 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) [illegible]

14 Informant Elizabeth Carter
(Address) 767 W Mulberry St

15 APR 16 1924 By ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Autopsy or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asthma (from History)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) I do not know

(duration) yrs. mos. ds.

(Signed) W K Grove, M. D.
(Coroner.)

4-15, 192 4 (Address) 117 N Gaulden st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cem	Apr 16 192 4
20 UNDERTAKER John H. Jordan	ADDRESS 142 Ostend st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4125 Resterstown Road St. 15 Ward)

Registered No. 101-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence L. Francis

(a) Residence No. 4125 Resterstown Road St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~Sex~~, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Francis

6-DATE OF BIRTH (month, day and year) March 24-1859

7-AGE, 65 yrs. — mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Riley S. Williamson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Levinia Pearce

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Charles Francis

(Address) 4125 Resterstown Road

15-

APR 16 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 13-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1924, to April 13, 1924.

that I last saw her alive on April 13, 1924

and that death occurred, on the date stated above, at 9.05 A.m.

The CAUSE OF DEATH* was as follows:

Uraemia

Lobar Pneumonia

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Chronic diffuse Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James D. Adelmot, M. D.

(Address) 4012 Pimlico Rd

Apr 14 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Western	April 16 1924
20-UNDERTAKER,	ADDRESS
Horace H. Burgee	363 Falls Road

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 85959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85959

CERTIFICATE OF DEATH.

41

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2438 Guilford av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adolphus H. Trueheart

(Residence in Baltimore: No. 2438 Guilford av St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, ..., 1838
(Month) (Day) (Year)

7-AGE, 86 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

9-BIRTHPLACE, (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, William F Trueheart

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss. Bessie Trueheart

(Address) 2438 Guilford Av

APR 16 1924 ROBERT R. KRAUTER,
Filed ..... 191.....
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 15, 1924
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1924, to April 15 1924, that I saw him alive on April 14 1924, and that death occurred, on the date stated above, at 3 PM. m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia (Pneumonia)
Secondary to Contraction of Lower Lobes
Tobacco

(Duration) ..... yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) ..... yrs. mos. 7 ds.

(Signed) Howard A. Warner M. D.

April 15, 1924. (Address) 2607 Garrison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Pk. DATE OF BURIAL, April 17, 1924

20-UNDERTAKER N. Fahey Sons. ADDRESS 1827 N North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85960

CERTIFICATE OF DEATH.

100 001 ✓ D 85960

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice Dunham

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854

7-AGE.	If LESS than 1 day,
70 yrs. mos. ds.	hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, David Dunham

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Dorcas Wood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant). Municipal Hospital Records

(Address).

15- Filed APR 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-13-24

17- I HEREBY CERTIFY, That I attended deceased from 3-21, 1924 to 4-13, 1924

that I last saw h. alive on 4-13, 1924

and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude E. A. Dunn, M. D.

4-14, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Old Harford Church Cemetery Harford Co Md	April 17th, 1924

20-UNDERTAKER,	ADDRESS
George J. Schilling & Sons	1126 E Monument St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85961 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85961

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3175-Chapel. SP. V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis A. Buchacz.

(a) RESIDENCE NO. 3175 Chapel. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 19 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Frank Buchacz

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Ozaszuska

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Frank Buchacz
(Address) 3175 Chapel St

15 APR 16 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Wm. Luther Blades, M. D.
(Coroner.)

4/15/24 192 (Address) 143 N. Remy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	April 16 1924
20 UNDERTAKER J W Ozaszuski	ADDRESS 435 Eastern

If death occurred in a hospital or institution, the person in charge of such institution should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 85962

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1017 Edmondson Ave, St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Knorr

(a) Residence No. 1017 Edmondson Ave, St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 73 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 1, 1845

7-AGE. 78 yrs. 5 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9-BIRTHPLACE (city or town) Germany (State or Country),

PARENTS.

10-NAME OF FATHER, Ferdinand Knorr

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Sophia Berger

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14- (Informant) Helen Knorr

(Address) 1017 Edmondson Ave

15- APR 16 1924 ROBERT R. KRAUTER, Burial Permit ~~Clerk~~.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apl 13" 1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 1st 1924 to Apl 13th 1924 that I last saw her alive on April 13th 1924 and that death occurred, on the date stated above, at 845 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) E. A. Knorr, M. D

. 19 (Address) 725 Fidelity Bldg

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	4/16, 19 24
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Wm J Cole

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85963

CERTIFICATE OF DEATH.

188-003 D 85963

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. J. Cole

(a) RESIDENCE NO 45-6 E Federal ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cole

6 DATE OF BIRTH (month, day, and year) May 10 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unkn.

14 Informant Mary Cole
(Address) 45 E Federal St

15 Filed APR 16 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(duration) yrs. 9 mos. 7 ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(duration) 1 yrs. 6 mos. 6 ds.

(Signed) T. F. Farrell, M. D.
(Coroner.)

4-16, 1924 (Address) 117 N Gaulton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem | DATE OF BURIAL 4/16 1924

20 UNDERTAKER Mrs. R. G. Elliott | ADDRESS 225 Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85964 HEALTH DEPARTMENT—CITY OF BALTIMORE 41 D 85964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 400 S. Caroline St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Sylvester

(a) Residence No. 400 S. Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Sylvester

6-DATE OF BIRTH (month, day and year) Oct. 21-1853

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Policeman

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Leo Sylvester

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Barbara Powell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Elizabeth Sylvester

(Address) 400 S. Caroline St.

15- APR 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/14/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1924, to Apr. 14, 1924, that I last saw h[illegible] alive on Apr. 14, 1924 and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Infected Bedsore

(Duration) 20 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Necropsy

(Signed) Robert Krauter, M. D.

, 19 (Address) 340 Atlantic

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pikesville Cemetery — DATE OF BURIAL, April 17, 1924

20-UNDERTAKER, John A. Moran — ADDRESS 2 Balto St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Amelia

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85965

146

CERTIFICATE OF DEATH.

D 85965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 6 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Catharine Amelia.

(a) RESIDENCE NO. 18 N. Kenwood St., ... WARD ....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred .... yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Amelia.

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer ....

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Sully

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Cath. Kehoe

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Records (Address) ....

15 Filed APR 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/24

17 I HEREBY CERTIFY, That I attended deceased from 3/27/24, 19.., to 4/17/24, 19.., that I last saw h.. alive on 4/17/24, 19.., and that death occurred, on the date stated above, at 6:45 m.

The CAUSE OF DEATH* was as follows:

Puerperal Infection

.... (duration) .... yrs. 1 mos .... ds.

CONTRIBUTORY (Secondary) Malignant Endocarditis

Long Interval. (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Microscopic

(Signed) K. W. Skelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 17, 1924
20 UNDERTAKER John A. Moran	ADDRESS 1000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A FERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—t-12-23—M&T—100 Bks.

85966 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 85966

1-PLACE OF DEATH Govn mount Av E 30 St

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos Nelson Clifford.

(a) RESIDENCE NO. 335 E 30 St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10 - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	9	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School-Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank J. Clifford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Mc Nancy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Frank J. Clifford
(Address) 335 E 30 St

15 Filed APR 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows: Auto Accident

Fracture of Skull. Instant
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Clinton Blades, M. D.
(Coroner)

4/15/24, 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 4/16 1924

20 UNDERTAKER Chas R Krauet Son 1110 W. Mt Royal Ave — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dante Cichelli D 85967

CERTIFICATE OF DEATH. 101-001

D 85967

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. City Hosp. WARD) 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Master Dante Cichelli

(a) RESIDENCE NO. 2010 E Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Cichelli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Dora Ruer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Cichelli (Address) 2010 E Lafayette

15 Filed APR 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1924, to 4-15, 1924, that I last saw him alive on 4-15, 1924, and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

3 mos. 10 ds. (duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M.D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Apr 18 1924

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85968

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 85968

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2315 E. Fayette St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Annie Schultz

(a) Residence No. 2315 E. Fayette St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Schultz

6-DATE OF BIRTH (month, day and year) 2/12/1867

7-AGE, 57 yrs. 2 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) John Schultz

(Address) 2315 E. Fayette

15- Filed APR 16 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/14/1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 17 1923 to Apr 14 1924

that I last saw h.. alive on Apr 14 1924

and that death occurred, on the date stated above, at 7.55 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. B. Kanes M. D.

Apr [illegible], 1924 (Address) 201 N Rat Rt

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. W. W. Williams Cem. DATE OF BURIAL. Apr 17, 1924

20-UNDERTAKER. John Ullrich ADDRESS Rock & Ellum

SHOULD BE CAREFULLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-083 D 85969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 8 WARD)

2-FULL NAME Henry Beter

(a) RESIDENCE NO. 1639 N. caroline ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Beter (Burckley)

6 DATE OF BIRTH (month, day, and year) March 1/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary A. Beter
(Address) 1639 N. Caroline

15 Filed APR 16 1924 192 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock-struck by automobile

(Inquest to be held April 17/24)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Bauer, M. D.
(Coroner.)

Apr 15/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Wood Cem

DATE OF BURIAL Apr 17 1924

20 UNDERTAKER John Ellerios

ADDRESS 248 Ream

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 85970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D 85970

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 913 Harris alley St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Burke

(a) Residence No. 913 Harris alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of -

6-DATE OF BIRTH (month, day and year) March 14 1924

7-AGE. — yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) infant

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country) Balto., Md

PARENTS.

10-NAME OF FATHER, Benjamin F. Burke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Annapolis Md.

12-MAIDEN NAME OF MOTHER, Martha L. Rettenbruger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

11- (Informant) Benj. F. Burke

(Address) 913 Harris alley

13- APR 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 16-1924

17- I HEREBY CERTIFY, That I attended deceased from April 8 1924 to April 16 1924

that I last saw her alive on April 15 1924

and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Pertussis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

4/16 1924 (Address) 1014 Dillwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cem. DATE OF BURIAL. April 17, 1924

20-UNDERTAKER. Zirkler + Zirkler ADDRESS 1739 E. Eager St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 85971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-802

D 85971

1-PLACE OF DEATH Colonial Home

CITY OF BALTIMORE: (No. 11½ N. Mount St. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wagner

(a) RESIDENCE NO. 3157 W. Centralave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days 3 hours If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Walter Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Indiana

12 MAIDEN NAME OF MOTHER Mabel Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant Walter Wagner

(Address)

15 Filed APR 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1924 to April 15, 1924

that I last saw her alive on April 15 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Since Birth (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. Valentine Sprague, M. D.

, 19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL April 16 1924

20 UNDERTAKER Kendel Dyer & Son

ADDRESS 378 N.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85972

CERTIFICATE OF DEATH.

90

D 85972

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 N Fulton Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelaide E Parkhill

(a) Residence No. 707 N Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas Parkhill

6-DATE OF BIRTH (month, day and year) Jan-15-1853

7-AGE. 71 yrs. 2 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, H. McAllister

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Chas Parkhill

(Address) 707 N Fulton Ave

15- Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

APR 16 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 23, 19 23 to Apr. 16, 19 24

that I last saw h.. alive on Apr. 16, 19 24

and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Hypertension

Myocardial Insufficiency

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John T Krug Jr, M. D

Apr. 16, 1924 (Address) 1208 Eutaw Pl, Balto. Md.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL, April 17, 1924

20-UNDERTAKER W A Inchmeat Sons ADDRESS Walk Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 85973

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1705 Harlem Ave 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eliza Lorenty

(a) Residence No. 1705 Harlem Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Marcellus Lorenty

6-DATE OF BIRTH (month, day and year) Sept. 5 1837

7-AGE, 85 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). W. Va.

PARENTS.

10-NAME OF FATHER Alexander Austen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Augusta Co Va

12-MAIDEN NAME OF MOTHER, Mary Hunter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Miss Virginia Lorenty
(Address) 1705 Harlem Ave

15- APR 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 14 1924

17- I HEREBY CERTIFY, That I attended deceased from March 19 24 to Apr. 14 19 24

That I last saw h[illegible] alive on Apr. 14 19 24

And that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Artero-sclerosis

(Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

4/16 1924 (Signed) Homer Ch. Todd M. D.
(Address) 735 N Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem DATE OF BURIAL. Apr 17 1924

20-UNDERTAKER. Wm Pickner & Sons ADDRESS North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Mirabile)

HEALTH DEPARTMENT—CITY OF BALTIMORE

3-001

D 85974

14 D 85974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnold Marabli Mirabile

(a) RESIDENCE NO. 266 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Carmello Marabli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Chillipolli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Marabli

(Address) 266 N Exeter St

15 Robert F. Harrison, .19

Registrar

APR 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-12, 1924, to 4-14, 1924,

that I last saw h.. alive on 4-14, 1924,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Incomplete abortion

(over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-12-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Norwood Wilson, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent — DATE OF BURIAL April 17th 1924

20 UNDERTAKER Frank V. Pipitone — ADDRESS 1800 E 32nd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85975

D 85975

CERTIFICATE OF DEATH. X 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruby Gill Manuel.

(a) RESIDENCE NO. Choptank Md. ST., WARD Caroline Co.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 19-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Choptank (State or country) Md

PARENTS

10 NAME OF FATHER George Manuel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records
(Address)

15 Filed Robert F. Harrison Registrar

APR 16 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 19 24

17

I HEREBY CERTIFY, That I attended deceased from Feb-19, 19 24, to April 11, 19 24

that I last saw h alive on April 11, 19 24,

and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Signs + symptoms

(Signed) R. F. Ruby, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	April 16 19 24
20 UNDERTAKER	ADDRESS
Wm Isles Sr & Sons	1707 N Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 85976

Registered No. 179

1-PLACE OF DEATH

City of BALTIMORE: (No. 1710 N. Washington St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Albrecht

(a) Residence No. 1710 N. Washington St., Ward

(Usual place of abode) about

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced, HUSBAND (~~of~~) ~~WIFE~~ of late Augusta Albrecht.

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. about 80 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14- (Informant) Miss Lillie E. Albrecht

(Address) 1710 N. Washington St.

15- Dated APR 16 1924 192.. Robert P. Harris, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1923 to April 16 1924 that I last saw him alive on April 8 1924 and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Tumor Sphenoid

Endocranitis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nil

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. D. Thomas M. D.

Apr 6 1924 (Address) 1228 Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: April 18 1924

20-UNDERTAKER: Henry Horck Son — ADDRESS: 301 E. Eager St.

APR 16 1924

Burial Permit Work.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85977

CERTIFICATE OF DEATH.

129

D 85977

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 230 W. Lanvale St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Marie Shriver

(a) Residence No. 230 W. Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas F. Shriver

6-DATE OF BIRTH (month, day and year) Oct. 28–1860

7-AGE. 63 yrs. 5 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER Cornelius Rourke

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Irena

12-MAIDEN NAME OF MOTHER Theresa R. Wheeler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

14-INFORMANT (Informant) Thomas F. Shriver

(Address) 230 W. Lanvale St.

15- Robert P. Harris

19 Registrar.

PR 16 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 15–1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 22 19 17 to Apr 15 19 24

that I last saw her alive on Apr 15 19 24

and that death occurred, on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Cardiac hypertrophy & dilatation

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. 28 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Jno A Luetscher, M. D

19 (Address) 1025 Madison

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. April 17 19 24

20-UNDERTAKER Chas. F. Evans & Son

ADDRESS 1180 W. Mt. Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85978

CERTIFICATE OF DEATH.

D 85978

100-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Spring Hill Ave ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Mary Isabelle Muhl

(a) RESIDENCE NO. 2704 Spring Hill Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry W. Muhl

6 DATE OF BIRTH (month, day, and year): May 19, 1860

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mr. Joseph Kauffman
(Address) 2904 Spring Hill Ave.

15 Filed APR 16 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1924

17 I HEREBY CERTIFY, That I attended deceased from 12 April, 1924, to 14 April, 1924, that I last saw her alive on 14 April, 1924, and that death occurred, on the date stated above, at 3.10 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical findings

(Signed) Horace W. Byers, M. D.

, 19 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Parks Cemetery — DATE OF BURIAL: April 18, 1924

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 125 E. North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Brumback, 1531 E Gaither Cem 2078

10-2 / Exam

D 85979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85979

CERTIFICATE OF DEATH.

X 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1972 Pattison Place St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvira Stone Russell

(a) Residence No. Sykesville Md St., Ward Sykesville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward F.

6-DATE OF BIRTH (month, day and year) May 23 1853

7-AGE. 70 yrs. 10 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Edw. N. Childs

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sallie C Worden

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) Edward F Russell

(Address) Sykesville Md

15- Filed..... Robert [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apl. 14. 24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 20 1924 to Apl. 14 1924

that I last saw h[illegible] alive on Apl. 14 1924

and that death occurred on the date stated above at 9.10 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Chronic Nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Brumback M. D.

4-15- 1924 (Address) 1531 E. Northern

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Apl. 17	1924
20-UNDERTAKER,	ADDRESS
Fun Cole Co	Eutaw

APR 16 1924

Burial Permit Clerk.

U. S. WHITE PENCIL, WITH UNLEADED TIP. Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH clearly. AGE should be carefully supplied. OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 85980

CERTIFICATE OF DEATH. X 56 D 85980

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST. 4 WARD)

2-FULL NAME Antoinette Bazano.

(a) RESIDENCE NO. St. Vincent's Infirmary ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant B. Balsamo

(Address) 413 Gallatin St

15 Filed Robert P. Harrison Registrar

PR 16 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/8, 1924, to 4/16, 1924,

that I last saw h[illegible] alive on 4/[illegible], 1924

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

Rachitis

Convulsions - uncertain

(duration) uncertain yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John M. Edmonds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 4/17 1924

20 UNDERTAKER

ADDRESS

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85981

CERTIFICATE OF DEATH.

32 D 85981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 14 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Velma Durham

(a) RESIDENCE NO. 1419 Druid Hill ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Durham

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jennie Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed APR 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1924

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to ....., 19.....,

that I last saw h[illegible] alive on April 14, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Alex Jacobstein, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	April 17 1924
20 UNDERTAKER	ADDRESS
S. K. Brown & Son	708 W. Monty

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85982

CERTIFICATE OF DEATH.

D 85982

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Race ST. 23 WARD)

2-FULL NAME Elizabeth Burkett

(a) RESIDENCE NO. 1123 Race ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 2, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	11		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolgirl 6th

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Fla.

PARENTS

10 NAME OF FATHER: David Burkett

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Clora Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fla.

14 Informant: Clora Burkett

(Address): 1123 Race St.

Filed APR 1 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15/1924

17 I HEREBY CERTIFY, That I attended deceased from 3/4/1923, to 4/15/1924, that I last saw h[er] alive on 4/15/1924, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tbc

(duration) yrs. 12 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical microscopical

(Signed) [illegible], M. D.

, 19 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Apr 17 1924
20 UNDERTAKER	ADDRESS
J. R. Brown's Son	108 W. Monte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85983

101-001

CERTIFICATE OF DEATH ~~STILLBIRTH~~ No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

2-FULL NAME Baby Gladys Ivy Albrecht.

(a) RESIDENCE No. 930 N. Collington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/11/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			three hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Albrecht

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Mrs Wm ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hospital Record
(Address)

APR 13 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/24

17 I HEREBY CERTIFY, That I attended deceased from 4/11/24, 19.... to 4/11/24 19....,
that I last saw h~~e~~ alive on 4/11/24, 19....
and that death occurred, on the date stated above, at 5:50 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(6 mos.)

.... (duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) ....
.... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 14th 1924

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1126 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR STATISTICS

PORT 1924

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 85984

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3122 N. Calvert St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine C. Herzog

(a) Residence No. 3122 N. Calvert St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Herzog

6-DATE OF BIRTH (month, day and year) July 12, 1848

7-AGE. 75 yrs. 9 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) Camden
(State or Country), New Jersey

PARENTS.

10-NAME OF FATHER Rev. Dr. Andrew Schwartz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Christine High

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). New York

14-

(Informant) Charles Herzog

(Address) 3122 N. Calvert St

15-

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

APR 17 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from July 4 1923 to April 15 1924

that I last saw h[illegible] alive on April 15 1924

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Cortico Sclerosis

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. R. Hoen M. D

4-16. 1924 (Address) 5800 York Rd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cem.	April 18, 1924
20-UNDERTAKER.	ADDRESS
J. Sander Sons	1710 East St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85985

CERTIFICATE OF DEATH.

9 1-002

D 85985

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2109 Gough St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Julius Oestberg

(a) Residence No. 2109 Gough St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Oestberg

6-DATE OF BIRTH (month, day and year) 1848

7-AGE. 76 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Pattern-maker

(b) General nature of industry, business, or establishment in which employed (or employer) Weis Kettle & Co

(c) Name of employer... Stove Co

9-BIRTHPLACE (city or town) (State or Country), Denmark

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Denmark

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Denmark

14-

(Informant) Mrs. Johanna Oestberg

(Address) 2109 Gough St. St.

15-Filed APR 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 10 19 24 to Apr 16 19 24.

that I last saw h... alive on Apr 16 19 24.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Paralysis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. H. Mesa M. D

Ap 15, 1924 (Address) 1634 E Biddle.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Matthews Cemetery	April 17, 1924
20-UNDERTAKER.	ADDRESS
H. Sander & Sons	1710 Hart St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85986 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

31 ✓ D 85986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 147 S. Linwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily French

(a) Residence No. 147 S. Linwood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Robert L. French

6-DATE OF BIRTH (month, day and year): March 25, 1883

7-AGE: 41 yrs. — mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of Industry, business, or establishment in which employed (or employer): 037
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: William Hofmeister

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Bedericka Bratengeier

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

11- (Informant) Robert L. French
(Address) 147 S. Linwood Ave

13- Filed APR 17 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 19 24 to April 15 19 24
that I last saw h..e..alive on April 15 19 24
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Fibroid Tuberculosis

(Duration) 20 yrs. ? mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Grems M. D.
Apr 16, 1924 (Address) 1900 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge Cem.	April 18, 1924
20-UNDERTAKER,	ADDRESS
H. Sander Sons	1710 Pearl St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1924 46 1878

D 85987

CERTIFICATE OF DEATH.

1-001

D 85987

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1012 Mosher ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Jones

(a) RESIDENCE NO. 1012 Mosher St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jones

6 DATE OF BIRTH (month, day, and year) Mar 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah Ga

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Mrs Mary Shaw (Address) 1012 Mosher St

15 Filed APR 17 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 14, 1924, that I last saw him alive on 4/13, 1924, and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:

Enteric Fever

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W R Boyleston, M. D.

, 19 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 16 1924
20 UNDERTAKER	ADDRESS
Clarence Campbell	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85988

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 16 WARD)

REGISTERED NO. D 85988

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Levy

(a) RESIDENCE NO. 1721 Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Levy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Asher Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fatema Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Nathan Levy

(Address) 1721 Monroe st

15 Filed APR 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-24 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-14, 1924, to 4-16-, 1924,

that I last saw her alive on 12 a. m. 4-16, 1924,

and that death occurred, on the date stated above, at 12.10 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from rectum and mouth

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of liver and pancreas (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidor J. Jaw, M. D.

Apr. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Henning Run

DATE OF BURIAL 4/17 1924

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 85989

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85989

CERTIFICATE OF DEATH. x 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Pfeifer

(a) RESIDENCE No. Ruxton Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 4/1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	7	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER August Pfeifer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Hetrick

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant August Pfeifer
(Address) 112 S. Carlton St.

15 Filed APR 17 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental-Burns over surface of body- Clothes caught from while burning rubbish in yard.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Hollander, M. D.
(Coroner.)

Apr 18/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Apr. 17 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK. This CERTIFICATE and PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 85990 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 85990

CERTIFICATE OF DEATH.

1294

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Park Ave. Hamilton 0 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Laura V. Enocks.

(a) Residence No. South W. Central Ave. Above St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Randolph Enocks

6-DATE OF BIRTH (month, day and year) July 16/1850

7-AGE. 74 yrs. 9 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. George Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Julia Phillips

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country).

14- (Informant). Clara Schreiber

(Address) Park Ave Hamilton

15-

Filed ..... 192.. ROBERT R. KRAUTER Registrar.

APR 17 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 15/1924

17- I HEREBY CERTIFY, That I attended deceased from February 15th 1924, to April 15th 1924, that I last saw her alive on April 15th 1924, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) 1 ? mos. ? ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Schubert M. D.

. 19 (Address) 16 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	April 18 1924
20-UNDERTAKER	**ADDRESS**
Frank A. Fink	915 N. Gay St

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.— 1000 Bks.

D 85991

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+129 D 85991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N. Eden St. 22 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Young

(a) RESIDENCE. No. 505 N. Eden St., Ward South Carolina

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Young

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Alex. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Lacla Clarks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant John Young (Address) 505 Green St

15 Filed APR 17 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1924, to April 16, 1924

that I last saw h e alive on April 15, 1924

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Johnston M. D.

(Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville S. C. DATE OF BURIAL Apr. 18 1924

20 UNDERTAKER John H. Jordan ADDRESS 142 Ursula St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 03
85992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143-002
D 85992

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Carter

(a) RESIDENCE NO. 507 W. Lee St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Carter

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed APR 17 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 16, 1924, that I last saw her alive on April 16, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Rt Lower Lobe.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Ruptured ectopic pregnancy. (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at Johns Hopkins Hospital.

Did an operation precede death? Yes. Date of Apr 8, 1924

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) W. T. Linder, M. D.

, 19 (Address) Johns Hopkins Hospital Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Apr 19 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Utrick St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

85993

HEALTH DEPARTMENT---CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

D 85993

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 N Linwood ave St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Addie C McDaniel

(Residence in Baltimore: No. 731 N. Linwood ave St.; 64 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-~~SINGLE~~ ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): John H McDaniel

6-DATE OF BIRTH: Aug 12 (Month) (Day), 1844 (Year)

7-AGE: 80 yrs. 8 mos. 2 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): 0?

9-BIRTHPLACE (State or country): Maryland

PARENTS

10-NAME OF FATHER: Robert Henderson

11-BIRTHPLACE OF FATHER (State or country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah Payton

13-BIRTHPLACE OF MOTHER (State or country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsa Reese

(Address) 731 N Linwood ave

15- Filed APR 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 14th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb, 1924, to, April 14th 1924, that I saw h-er alive on April 14th 1924, and that death occurred, on the date stated above, at 6 50 m.

The CAUSE OF DEATH* was as follows:

Duodalatler Ulcer Heart

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Chronic Interstitial Nephritis

(Duration) unknown yrs. mos. ds.

(Signed) T. J. Jaukins M. D.

4/14 it 1924 [Address] 119 N Milton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: April 17, 1924

20-UNDERTAKER: Thos C. Miller

ADDRESS: 233 E Jefferson St.

Cor.—1-12-23—M&T—100 Blks.

D 85994

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003 D 85994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at Johns Hopkins Hospital St., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard L. Mason

(a) RESIDENCE NO. 808 N. Belnord Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb 3/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	3	2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James Mason

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Jay

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant James Mason
(Address) 808 N. Belnord Ave

15 Filed Apr 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed head & other injuries
Run over by autotruck
(Inquest to be held Apr 17/24
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mann (Coroner.) M. D.

Apr 17/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 19 1924
20 UNDERTAKER Wm T. Hartley	ADDRESS 815 N. Wash St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

85995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 85995

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N Aisquith ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Bowie

(a) RESIDENCE NO. 412 N Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (WIFE) Annie Bowie

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	Appox 75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co, Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant (Address) Katie Nelson daughter 410 N Aisquith St

15 Filed APR 7 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1924

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1924, to April 14, 1924, that I last saw him alive on April 13, 1924, and that death occurred, on the date stated above, at 9.10 A.m.

The CAUSE OF DEATH* was as follows:

General Septicemia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Tonsillitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R [illegible] M. D.

4/14, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	April 17, 1924
20 UNDERTAKER	ADDRESS
Milton Davis	315 N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85996

CERTIFICATE OF DEATH.

4 74-001

D 85996

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 W. Saratoga St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl Schon Jr.

(a) Residence No. 109 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Sierck

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE.	If LESS than 1 day,
59 yrs. -- mos. -- ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mfgr. Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer) 038

(c) Name of employer

9-BIRTHPLACE (city or town) Toledo

(State or Country). Ohio

PARENTS.

10-NAME OF FATHER. Carl Schon

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Marie Duerringer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Conrad C. Rabbe

(Address) 206 S. Broadway

15- Filed APR 17 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 15/24

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7 1922 to April 15 1924

that I last saw h.. alive on April 15 1924

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. a few hours ds.

CONTRIBUTORY (Secondary) Hyper Arterial Tension

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? L

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) [illegible] M. D

4-16 1924 (Address) 117 W Saratoga

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	4/17 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 85997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85997

162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Chandler

(a) RESIDENCE NO. 811 W Hatcoat ST., St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3-1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	X	X	5 das.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Vernon Byrd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mattie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed APR 17 1924 ROBERT R. KRAUFER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5- 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to April 5, 1924, that I last saw her alive on April 5, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of the newborn

(duration) Life. yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary anemia 2 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. H. Wesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS APR 17 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 85998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 85998

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 Colvin ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dan. Hancock

(a) RESIDENCE No. 318 N. Colvin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mary E. Stafford
(Address) 318 Colvin St.

15 Filed APR 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Coll. Dis. heart
Fatal Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

(Signed) W. J. Riley, M. D.
(Coroner.)

Apl. 17, 1924 (Address) 1039 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	4/17 1924
20 UNDERTAKER E. Hensley	ADDRESS 1128 Baddock

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 85999 HEALTH DEPARTMENT—CITY OF BALTIMORE D 85999

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1138 N.Fulton Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John S. F. Gates

(a) Residence No. 1138 N.Fulton Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.)
Male	White	Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Grace V. Gates,

6-DATE OF BIRTH (month, day and year) Feb. 11. 1870

7-AGE.	If LESS than 1 day,
53 yrs. 2 mos. 5 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Produce Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer). Himself

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Francis Gates,

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Penna.

12-MAIDEN NAME OF MOTHER. Mary Hartzell,

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Maryland

14- (Informant). Grace V. Gates,
(Address). 1138 N. Fulton Ave.

15- Filed APR 17 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit (illegible)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). APR 16 1924

17- I HEREBY CERTIFY, That I attended deceased from April 8, 19.24, to April 16, 19.24, that I last saw him alive on April 16, 19.24, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

.....(Duration).....yrs.....mos. 13 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Typing

(Signed) J. Thomas Gibson, M. D.

APR 17 1924 19.. (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	APR 19 1924, 19..

20-UNDERTAKER.	ADDRESS
Geo W. Little	EDMONDSON AVE.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86000

CERTIFICATE OF DEATH.

X 4/V D 86000

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

2-FULL NAME Robert E. White

(a) RESIDENCE NO. Chase, Balto Co, Md St.; WARD U C 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Post man

(b) General nature of industry, business, or establishment in which employed (or employer) Letter Carrier

(c) Name of employer 086

9 BIRTHPLACE (city or town) Chase Balto Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph White

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Doris Tull

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed APR 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 16, 1924,
that I last saw HIM alive on April 16, 1924,
and that death occurred, on the date stated above, at 8 45 7 m.

The CAUSE OF DEATH* was as follows:

Urinary Renal Calculus Diphtheritic Cystitis Generalized Septicaemia Pericarditis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Chase, Md.

Did an operation precede death? Stone created in bladder No incision Date of April 11-24

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture.

(Signed) Robert Wineray, M. D.

April 16 1924 (Address) John Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Md

DATE OF BURIAL 4/28 1924

20 UNDERTAKER Geo E French

ADDRESS Druid Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

(Rawson)

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 36001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36001

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 240 N. Pulaski ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Rawson

(a) RESIDENCE. NO. 240 N. Pulaski ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sam, Rawson.

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress (home.

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country) "

PARENTS

10 NAME OF FATHER Edw. Courtis

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Julia Cook
(Address) 240 N. Pulaski

15 Filed APR 17 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 8 1924 to Apr 13 1924

that I last saw her alive on Apr 12 1924

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) F. E. Smith, M. D.

Apr 14 (Address) Sixth Dist. Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	4/18/24 19
20 UNDERTAKER John A. Owens	ADDRESS 538

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86002

CERTIFICATE OF DEATH.

~~101-99~~ D 86002

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 N. Carey ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Lint, Jr.

(Residence in Baltimore: No. 1724 N Carey st St.; 64 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept (Month) 8 (Day), 1859 (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Elevator opr-Ob
(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale House

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jos. Lint

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Butler

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Caroline M Lint

(Address) 1724 N Carey st

15- Robert P. Harrison, Registrar.

Filed APR 17 1924 Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 16th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 11th 1924, to Apr 16th 1924, that I saw h[illegible] alive on Apr 16th 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None known

(Duration) yrs. mos. ds.

(Signed) Chas. J. Heller M. D.

April 17th, 1924. (Address) 22 W Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, April 19 1924

20-UNDERTAKER Wilbur W. Shriver ADDRESS 1015 Edmondson Ave

Spec.—1-10-21—M&T—1500 Bks.

D 86003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86003

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. M'D Genl Hosp'l ST. 28 WARD)

2-FULL NAME Miss Helen Bowen

(a) RESIDENCE NO. Edmondson Ave & Bedford Pl WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John Bowen

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Edith Timlis

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs Bessie Armstrong
(Address) Edmondson Ave & Old Frederick Rd

15 Robert P. Harrison, M.D.
Registrar

APR 17 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.16.24

17 I HEREBY CERTIFY, That I attended deceased from 4.12.24, 19..., to 4.16.24, 19...,

that I last saw her alive on 4.16.24, 19...,

and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Ch. Endocarditis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Cyanotic Paroxysm + Pulmonary Edema (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Armstrong M. D.

, 19 (Address) M'D Genl Hosp'l

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 18th 1924
20 UNDERTAKER	ADDRESS
Wilbur W. Shivers	1018 E Monument Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86004

CERTIFICATE OF DEATH.

188-B 3 86004

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Olga Brackowitz Brashewitz or Brosheltez

(a) RESIDENCE NO. 206 S Green st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) October 18, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) No
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Brashewitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mart Lapachuk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mart Brashewitz
(Address) 226 South Green Street

15 Filed APR 17 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or~~ inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Shock

(duration) yrs. a few hrs. ds.

CONTRIBUTORY (Secondary) Struck by Auto truck

(duration) yrs. mos. ds.

(Signed) W K Gormley, M. D.
(Coroner.)

4-17, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislowas — DATE OF BURIAL: April 19, 1924

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S Paca St

Burial Permit Clerk

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS' special statements of CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86005

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 S Schroeder ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A Melville

(a) RESIDENCE NO. 132 S Schroeder ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white.	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Osburn

6 DATE OF BIRTH (month, day, and year) Apr 1 - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bartender

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Frank J Melville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Rafferty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Ellen Melville (Address) 132 S Schroeder St

15 Apr 17 1924 Robert F. Murphy Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/1/24 19.. to 4/15/24 19..

that I last saw h.. alive on 4/11/24 19..

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Pyaemia Duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas J Cowan, M. D.

4/16/24 (Address) 1108 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
New Cathedral Cem	Apr 19 1924
20 UNDERTAKER Thomas J Cowan & Son	ADDRESS 901 Hollins St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86006

CERTIFICATE OF DEATH.

14-001 ✓

D 86006

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1929 West Mulberry St. N Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frederick A. Ahrensen

(a) Residence No. 1929 West Mulberry St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE Minnie Ahrensen

6-DATE OF BIRTH (month, day and year) Apr 14th 1864

7-AGE, 60 yrs. 0 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Brewer

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Walter R. Ahrensen

(Address) 1929 West Mulberry

15- FILED APR 17 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 15th 1924

17- I HEREBY CERTIFY, That I attended deceased from April 11, 1924, to April 15, 1924

that I last saw him alive on April 15, 1924,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 5 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) E. M. Lumpkin M. D.

April 17 1924 (Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn

DATE OF BURIAL, 4/18/24 19....

20-UNDERTAKER, Geo. Weber & Son

ADDRESS 2303 Edmondson Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Stanislaw Biedzycki)

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86007

D 86007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Biedzycki Stanislaw

(a) RESIDENCE NO. 5322½ Bethel ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Czeslawa Budrzycki

6 DATE OF BIRTH (month, day, and year) May. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	38	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Seaman

(b) General nature of Industry, business, or establishment in which employed (or employer) Stevedore. 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Czeslawa Budrzycki (Address) 5322 N. Bethel St.

15 Robert P. Mayfield, Registrar

APR 17 1924 .19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1924

17

I HEREBY CERTIFY, That I attended deceased from 4/11 .1924. to 4/15 .19 24

that I last saw him alive on 4/15 .19 24.

and that death occurred, on the date stated above, at 10 15 p m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer — which was followed by a gastro-enterostomy 4/11/24

(Duration) 3 yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Concealed hemorrhage

& terminal Sepsis (Duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 4/11/24.

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Emil Novak per wcw M. D.

4/15 1924 (Address) 26 E. Preston St. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 4/18 1924

20 UNDERTAKER William Fiallkowski

ADDRESS 1618 Eastern

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86008

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 86008

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.) 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida L. Chenowith

(a) RESIDENCE NO. 4002 Falls Rd (ST.) (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard A. Chenowith

6 DATE OF BIRTH (month, day, and year) Oct. 19-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Robert McLaren

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary L. Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Richard A. Chenowith
(Address) 4002 Falls Road

15 Filed ..... Robert F. ..... .19 .....
Registrar

Burial Permit Clerk.

APR 17 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to April 16, 1924.

that I last saw h[illegible] alive on April 16, 1924,

and that death occurred, on the date stated above, at 7 12 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Septicemia
Phlebitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma breast
Varicose veins (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4002 Falls Road.

Did an operation precede death? Yes Date of Mar. 12/24

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Sybert, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	April 19 1924
20 UNDERTAKER	ADDRESS
Horace R. Burgee	3631 Falls Rd.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86009

CERTIFICATE OF DEATH.

D 86009

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5114 Reisterstown Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Ruth A. Bull

(a) Residence No. 5114 Reisterstown Road St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Stanfield P. Bull

6-DATE OF BIRTH (month, day and year) June 28-1893

7-AGE, 30 yrs. 9 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)... 37

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Stephen P. Keiffer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Emma V. Collins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Stanfield P. Bull

(Address) 5114 Reisterstown Road

15- Filed APR 17 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 15-1924

17- I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to April 15, 1924, that I last saw her alive on June 15, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cordiac Dilatation

Sudden

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of...

Was there an autopsy? No

What test confirmed diagnosis?...

(Signed) L. A. Richardson, M. D.

April 19 1924 (Address) 117 W. 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, April 18, 1924
20-UNDERTAKER, Horace F. Burgee	ADDRESS 363 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86010

CERTIFICATE OF DEATH.

1 29 D 86010

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 854½ W. Lombard ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Pravadzevicius

(a) RESIDENCE. NO. 854½ W. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Anele Pravadzevicius

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coat Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Mens Clothing

(c) Name of employer None past 3 years.

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Joseph Pravadzevicius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Anele Pravadzevicius (Address) 854 W. Lombard St.

15 Filed APR 17 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 1921, to April 15, 1924, that I last saw him alive on April 15, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 13 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Renal insufficiency

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) John A. Buchness, M. D.

, 19 (Address) 650 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Redeemer Cemetery	April 20 19
20 UNDERTAKER	ADDRESS
Chas. B. Kuchanchka	637 S. Paca St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Block

Spec.—1-10-21—M&T—1500 Bks. (Richard W. Amos)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86011 D 86011

CERTIFICATE OF DEATH. +90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St. Joseph's Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Richard) R. W. Amos

(a) RESIDENCE NO. 914 N. St. Spanner Point Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Geo Loeffler

(Address) Equitable Bldg

Robert F. Harrison, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1924, to April 17, 1924;

that I last saw her alive on April 17, 1924;

and that death occurred, on the date stated above, at 7:00 PM.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Valvular Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Schenuch M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catonsville Md DATE OF BURIAL 4/17 1924

20 UNDERTAKER Robert Burkhardt ADDRESS Catonsville Md

PR 17 1924

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4819 Ferndale ave St., 28 Ward) 74-001

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian N. Owings

(a) Residence No. 4819 Ferndale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	White	Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elisha Owings

6-DATE OF BIRTH (month, day and year) Sept 18 42

7-AGE. 81 yrs. 6 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER Nathaniel Nelson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Matilda Poole

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) G. L. Hickman

(Address) 4819 Ferndale ave

15- Filed APR 7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 5 1924 to Apr 15 1924

that I last saw her alive on Apr 12 1924

and that death occurred, on the date stated above, at 9-20 a m.

The CAUSE OF DEATH* was as follows:

Asthma Collapse

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. C. Symington, M. D.

Apr 15 1924 (Address) 4309 Liberty Hgts

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New London Md.	April 8 1924
20-UNDERTAKER.	ADDRESS
N M Routson	2230 N Milton

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86013 ✓ D 86013

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

2-FULL NAME John J. Hartigan

(a) RESIDENCE NO. 522 N. Paca ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Mary Hartigan

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Actor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER J. J. Hartigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Dooley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Hartigan (Address) 522 N Paca St

15 Filed APR 1 1924 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15, 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1924 to Apr. 15, 1924, that I last saw him alive on Apr. 15, 1924, and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) S. W. Brazzell, M. D.

19 (Address) 1813 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	Apl 18 1924
20 UNDERTAKER Jahrens & Co	ADDRESS 1611 Mad

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86014

CERTIFICATE OF DEATH.

49 D 86014

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Braddish Ave Ward 15)

2-FULL NAME Carrie Simson

(a) RESIDENCE NO. 1805 Braddish Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Felix Simson

6 DATE OF BIRTH (month, day, and year) ? 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Thos Gaunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Sally Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John Davis Sister

(Address)

15 Filed APR 17 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct-15, 1923, to April 17, 1924.

that I last saw h alive on April 17, 1924

and that death occurred, on the date stated above, at 11,30 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Mediastinum with metastasis of Lungs

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Martin W Strauss M. D.

(Address) 8043 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	4/20 1924
20 UNDERTAKER	ADDRESS
J. Ahrens Co	1611 Mad Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86015

CERTIFICATE OF DEATH.

X 90 D 86015

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Henry Price

(a) RESIDENCE NO. New York City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Stewart Price

6 DATE OF BIRTH (month, day, and year): Dec 19/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	73	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Doctor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): St Clair

PARENTS

10 NAME OF FATHER: Mukuous

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1924, to April 17, 1924, that I last saw h... alive on April 17, 1924, and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Aptero-Sclerosis and pyelonephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation for Benign Prostatic Hypertrophy (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 14 '24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. Boyd Love, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery N.Y. DATE OF BURIAL: April 19, 24

20 UNDERTAKER: John J. Mitchell ADDRESS: 1201 W. Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86016

D 86016

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 E. North ave ST., 9 WARD)

2-FULL NAME Josephine R. Jones

(a) RESIDENCE NO. 321 E. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	70	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George W. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Hannah A. Glackner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Miss Ida B. Jones

(Address) 321 E. North ave

15 Filed 19 ROBERT R. KRAUTER, Registrar

APR 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/16, 1924, to 4/17, 1924.

that I last saw her alive on 4/17, 1924

and that death occurred, on the date stated above, at 4 35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Several (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Geo. W. Hoff, M. D.

4/18 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	April 19 1924
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 86017

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 86017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 Washington Blvd ST.; 22 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew Skladowsky

(Residence in Baltimore: No. 638 Washington Blvd St.; 30 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED.~~ (*Write* the word.) Widowed

6-DATE OF BIRTH, March 12, 1854
(Month) (Day) (Year)

7-AGE, 69 yrs. 1 mos. 1 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Lithuania

PARENTS.

10-NAME OF FATHER. Jacob Skladowsky

11-BIRTHPLACE OF FATHER (State or Country). Lithuania

12-MAIDEN NAME OF MOTHER Agata Blouski

13-BIRTHPLACE OF MOTHER (State or Country). Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Skladowsky

(Address) 638 Washington Blvd.

15-

APR 18 1924

ROBERT R. KRAUTER
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 17, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 30 1924, to April 17 1924, that I saw h[illegible] alive on April 17 1924, and that death occurred, on the date stated above, at 4 45 p.m.

The CAUSE OF DEATH* was as follows: (a) Fracture of right leg

(b) Gangrene of right arm

(Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Cancer of right arm

(Duration) yrs. mos. 2 ds.

(Signed) Wm. J. Lyon M. D.

April 17, 1924 (Address) 411 W. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 638 Washington Blvd

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer

DATE OF BURIAL. April 20, 1924

20-UNDERTAKER John J. Gribbin

ADDRESS 426 S. Paca St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86018

CERTIFICATE OF DEATH.

D 86018

1-PLACE OF DEATH Christ Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dorsey

(a) RESIDENCE NO. 704 Ensor ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11 - 1924

7 AGE — Years | Months | Days: 5 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Joseph Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Rida West

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Rida Dorsey (Address) 704 Ensor St

15 Filed APR 18 1924 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1924. to April 16. 1924.

that I last saw living on April 16, 1924.

and that death occurred, on the date stated above, at 1205 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. L. Wiseman, M. D.

4/16 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel ct — DATE OF BURIAL: April 1924

20 UNDERTAKER: J. L. Brown & Son — ADDRESS: 108 W. Mount

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86019

CERTIFICATE OF DEATH.

D 86019

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 E Northwood ST., 8 WARD)

2-FULL NAME Elizabeth Bauermeschmidt

(a) RESIDENCE NO. 1649 E North ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Bauermeschmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretta Weisner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Sarah Bauermeschmidt
(Address) 1649 E North ave

APR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I attended deceased from November, 1923, to April 16, 1924, that I last saw her alive on April 16, 1924 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum & peritoneum

(duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Myelolatic Hydrothorax & Ascites (duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Nov. 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) A. D. Atkinson, M. D.

April 17, 1924 (Address) 1010 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 19th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86020

CERTIFICATE OF DEATH.

74-001 ✓

D 86020 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm White

(a) Residence No. 526 N. Mulberry St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eliz. Lively

6-DATE OF BIRTH (month, day and year) 1859

7-AGE, 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick White Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Irelan " "

12-MAIDEN NAME OF MOTHER, Wmps Walles " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Irelan " "

14- (Informant) Mrs Eliz White

(Address) 526 N. Mulberry St

15- APR 18 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-16-1924

17- I HEREBY CERTIFY, That I attended deceased from April 13, 1924 to April 16 1924

that I last saw her alive on April 16 1924

and that death occurred, on the date stated above, at 12 15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Disease Chr. Nephritis

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) S. Goldman M. D

, 19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa — DATE OF BURIAL, 4/18 1924

20-UNDERTAKER, Gorsuch Early Fulton & Fayette — ADDRESS

PLACE RESERVED FOR BINDING.

UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86021

CERTIFICATE OF DEATH.

128 D 86021

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1137 S. Paca St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Stemler

(a) Residence No. 1137 S. Paca St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6-DATE OF BIRTH (month, day and year) Feb 28 1864

7-AGE, 60 yrs. 1 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Wagners Oyster Packer

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Stemler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Elizabeth Stemler

(Address) 1137 S. Paca

15-

Filed APR 18 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 16 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1924, to Apr. 16, 1924, that I last saw h.. alive on Apr. 16, 1924, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Harley Stoney, M. D.

Apr 16 1924 (Address) 1 E Ward St Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cedar Hill	4/19 1924
20-UNDERTAKER. Wm Cook	ADDRESS 502 E Ward.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Elizabeth Mueller

D 86022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86022

131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital Balt md REGISTERED NO.

CITY OF BALTIMORE: (No. Elizabeth Mueller WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 132 N Dallas St.

(a) RESIDENCE NO. 1 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28th 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School 6b

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) md. (State or country)

12 MAIDEN NAME OF MOTHER Cath Mahler

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14 Informant Hospital Record.

(Address)

15 Date APR 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/24

17 I HEREBY CERTIFY, That I attended deceased from 4/9/24, 19..., to 4/16/24, that I last saw h[illegible]ive on 4/16/24 6 P.M. and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelly M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 21 1924
20 UNDERTAKER	ADDRESS
Geo. J. Rulle	1735 Harford Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

171 P 086023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 86023

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 19 WARD)

2-FULL NAME Lillian Brown

(a) RESIDENCE NO. 326 N. Bruce St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Arter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Record

(Address) JOHNS HOPKINS HOSPITAL.

Filed APR 18 1924 , 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 17, 1924, that I last saw her alive on April 17, 1924, and that death occurred, on the date stated above, at 1.50 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 2 mos (?) ds.

CONTRIBUTORY (Secondary) Secondary pneumonia

(duration) 0 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X ray - Pirquet test

(Signed) H. H. Wasch, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 4/20 1924

20 UNDERTAKER Mr. S. James H. Dennis

ADDRESS 1303 Pressman St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86024

D 86024

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 Jackson Place St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harby H Binnerman

(a) Residence No. 108 Jackson Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Sing'l

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 60 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Merchant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Charles Binnerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Mollie Hillman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis
(Address) 1439 E Balto St

15- APR 18 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4-18-24

17- I HEREBY CERTIFY, That I attended deceased from January, 1921, to April 18, 1924, that I last saw him alive on April 18, 1924, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Diabetis Mellitus

(Duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris majoris

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) M. H. Bramonitz M. D.

, 19 (Address) 1705-7 E. Baltimore St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pikesville Jewish Cem.	April 18 1924
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 86025

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ... JOHNS HOPKINS HOSPITAL ST. 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Shirley Winston

(a) RESIDENCE NO. 3708 Eutaw Place ST. ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER Albert Winston

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Belle Goldman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed APR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to April 18, 1924, that I last saw him alive on April 18, 1924, and that death occurred, on the date stated above, at 1:15 p m.

The CAUSE OF DEATH* was as follows:

Enlarged thymus

(duration) (Life) yrs. mos ds.

CONTRIBUTORY (Secondary) Cyanotic attacks 1 January

(duration) yrs. mos. 1 X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund N. Kerper, M. D.

4/18, 1924 (Address) Johns Hopkins Hosp. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL 4/18 1924

20 UNDERTAKER: Jack Levis — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86026 — 101-6 01 V — D 86026

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 27 WARD)

2-FULL NAME Joshua Franklin Stockdale (Grocer)

(a) RESIDENCE NO. 50 S. Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Nellie R. Stockdale

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 86

(b) General nature of industry, business, or establishment in which employed (or employer) Pattern Maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Stockdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Record (Address)

15 Filed APR 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/24

17 I HEREBY CERTIFY, That I attended deceased from 4/12/24, 19..., to 4/17/24, 19...,

that I last saw h~~e~~ alive on 4/17/24, 19...,

and that death occurred, on the date stated above, at 5. a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Infant Pt Lung

(duration) yrs. mos. 1X ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) K. W. Kelly, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemy — DATE OF BURIAL: April 19 24

20 UNDERTAKER: Jos Jacobs & Son — ADDRESS: 2178 Pa.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86027

CERTIFICATE OF DEATH.

52 D 86027

1-PLACE OF DEATH 1205 S. Chapel St.

CITY OF BALTIMORE: (No. ..... ST., V WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Smith

(a) RESIDENCE NO. 1205 S. Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Cora Banks

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant
(Address)

15 APR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1924, to April 8, 1924, that I last saw him alive on April 8, 1924, and that death occurred, on the date stated above, at 6-30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Failure; Chronic Rheumatic Endocarditis.

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination.

(Signed) Cooper Jewett, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel cemetery — DATE OF BURIAL: April 15 1924

20 UNDERTAKER: Edward Bryan — ADDRESS: 631 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86028

CERTIFICATE OF DEATH.

178 D 86028

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1426 E. Oliver ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matilda Trainor

(a) RESIDENCE NO. 1426 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Trainor

6 DATE OF BIRTH (month, day, and year) June 1/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	55	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James P. Trainor
(Address) 1426 E. Oliver St.

APR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock-fright-house afire

(duration) yrs. mos. ds.

(Signed) J. H. Haller, M. D.
(Coroner.)

Apr 17/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem Cathedral	July Sept 2/192[illegible]
20 UNDERTAKER	ADDRESS
Clark & Sons	1st & Bway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86029

CERTIFICATE OF DEATH.

X 101-001 ✓ D 86029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Stinchcomb

(a) RESIDENCE NO. Joppa, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Stinchcomb

6 DATE OF BIRTH (month, day, and year) Oct 9th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer 027

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frank Krock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant B. S. Mears
(Address) 446 Kenwood Ave

15 APR 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to April 18, 1924, that I last saw her alive on April 18, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab. & P. S.

(Signed) J. V. Szczerbicki M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington cemetery	4/20 19 24
20 UNDERTAKER E. B. Hartle	ADDRESS 1506 West Pr

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86030

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Hospital

CITY OF BALTIMORE: (No. 7 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin J. Schoch

(a) RESIDENCE NO. Oakland Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Schoch

6 DATE OF BIRTH (month, day, and year) Sept. 29. 1858

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
65	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saw Filer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER William Schoch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Lydia Kleintuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14

Informant Elizabeth Schoch

(Address) Oakland Md.

Filed APR 19 1924 P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 18, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1924, to April 18 1924.

that I last saw him alive on April 18, 1924

and that death occurred, on the date stated above, at 3:07 P m.

The CAUSE OF DEATH* was as follows:

Cancerous Stomach

Chronic Adhesive Pericarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 16, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation Clinical Findings

(Signed) Gaetano Panettieri, M. D.

, 19 Church Home and Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Md.	4-18-24 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

Spec.—1-10-21—M&T—1500 Bks.

D 86031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86031

CERTIFICATE OF DEATH.

X76

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp. ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morgan, Edwin S

(a) RESIDENCE NO. 158- Second Ave. N. ST., Nashville - Tenn

(Usual place of abode) WARD

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Edwin S. Morgan

6 DATE OF BIRTH (month, day, and year) Mch. - 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - Broker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER - Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Scruggs.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Reeves. J.W.H. (Address) .....

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 18, 1924, that I last saw him alive on April 18, 1924, and that death occurred, on the date stated above, at 4 40 P. m.

The CAUSE OF DEATH* was as follows:

Dementia paralytica -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Gas Bacillus infection

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? - Tenn

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Eugene Allen, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Nashville Tenn

DATE OF BURIAL 4-19 1924

20 UNDERTAKER Fenwick Jenkins & Sons Co

ADDRESS Mitchell & Brothers.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 19 1924

Spec– 12-23-21–E.B.R.S.–400 Bks.

BOLAND 621 Wash Blvd Cubic-2475 Lib 3 - 6F20

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86032 — 74-01 — D 86032

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 145 N. Front St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Bland

(a) Residence No. 145 N. Front St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas

6-DATE OF BIRTH (month, day and year) Jan. 26 1860

7-AGE. 64 yrs. 2 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) 837

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, James Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maine

12-MAIDEN NAME OF MOTHER, Mary Ann Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) James Davis

(Address) 3133 Hanover

15- Robert P. Harrison, M.D. Registrar.

PR 91974

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) February 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 14 1924 to Apr. 17 1924 that I last saw her alive on Apr. 15 1924 and that death occurred, on the date stated above, at 12-30 m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

(Duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Thrombosis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dilworth M. D

Apr 18 1924 (Address) 624 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	19 1924
20-UNDERTAKER.	ADDRESS
Wm Corkran & Son	

Grand Temple Elect

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr Blades 143 N. Bway

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36033

CERTIFICATE OF DEATH.

74-0 D 86033

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 West Lanvale ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Irving Ward

(a) RESIDENCE NO. 1510 West Lanvale ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Artist
(b) General nature of industry, business, or establishment in which employed (or employer) 101
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Julia A Hoover

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Florence Wheeler
(Address) 1510 W. Lanvale St

15 Filed ..... 192 Robert P. Harrison, Registrar

Burial Permit Clerk

APR 19 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Blades, M. D.
(Coroner)
3/18/24, 192 (Address) 143 N Bway

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgewood. DATE OF BURIAL Apr 19 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave.

* WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86034

CERTIFICATE OF DEATH.

90 D 86034

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Greenmount Ave, ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard J.Bandel

(a) RESIDENCE NO. 2403 Greenmount Ave, ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of single

6 DATE OF BIRTH (month, day, and year) Jan.8,1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber's Helper
(b) General nature of industry, business, or establishment in which employed (or employer) 059
(c) Name of employer Every Where

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Leonard J.Bandel

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Hays

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Emily S.Henderson
(Address) 2403 Greenmount.

15 Filed APR 19 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial
Insufficiency
(duration) yrs. mos ds.
CONTRIBUTORY Senility-Arterial-Scer-.
(Secondary)
(duration) yrs. mos. ds.
(Signed) J S H Palmer, M. D.
(Coroner.)
April 18 4, 192 (Address) 306 E.North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	4/21 1924
20 UNDERTAKER William Cook	ADDRESS 502 E Nor

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86035

1-PLACE OF DEATH

City of BALTIMORE: (No. 4115 Norfolk Ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frances M Armiger

(a) Residence No. 4115 Norfolk Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W.	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wilson Armiger

6-DATE OF BIRTH (month, day and year) Nov 2, 1861

7-AGE,	If LESS than 1 day,
62 yrs. 5 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Md

PARENTS.

10-NAME OF FATHER Hugh A Friel

11-BIRTHPLACE OF FATHER (city or town)..... Dulond
(State or Country).....

12-MAIDEN NAME OF MOTHER Margaret Dillon

13-BIRTHPLACE OF MOTHER (city or town)..... Dulond
(State or Country)..... Md

14- (Informant) Mrs Marie E Del Monte

(Address) 4115 Norfolk Ave

15- Robert F. Harrison, ... 192.....
Burial Permit Clerk. Registrar.

APR 1 91924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 18. 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1924, to Apr. 18, 1924, that I last saw her alive on Apr. 17, 1924, and that death occurred, on the date stated above, at 9.15 A m.

The CAUSE OF DEATH* was as follows:

Rt Hemiplegia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Wm L Rittenhouse, M. D.

Apr 18 1924 (Address) 1038 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Ten Eyck	Apr. 21, 1924
20-UNDERTAKER.	ADDRESS
Wm. Cook	502 E North Ave

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 86036

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 1001

D 86036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5715 Wilson Ave St. 21 WARD)

2-FULL NAME Mary A. Carpenter

(a) RESIDENCE NO. 5715 Wilson Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Alvin L Carpenter

6 DATE OF BIRTH (month, day, and year) Sept 8-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Edward L Ebert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Mary E Calder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs M E Ebert

(Address) 5715 Wilson Ave

Date APR 7 1924 Robert E. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4, 17, 1924.

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to April 17, 1924

that I last saw h.. alive on April 16, 1924,

and that death occurred, on the date stated above, at 2-30A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) W W Smith, M. D.

(Address) 3429 Chestnut Ave

4/16, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Apr 19 1924

20 UNDERTAKER A S Marshall 3539 Full Ad ADDRESS

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

D 86037

HEALTH DEPARTMENT—CITY OF BALTIMORE

54-001

D 86037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 323 S Pulaski ST., 70 WARD)

2-FULL NAME Mary Catherine Zimm

(a) RESIDENCE No. 323 S Pulaski ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Zimm

6 DATE OF BIRTH (month, day, and year) April 23 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John C Frankle

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna Bronsak

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Rudolph Zimm

(Address) 323 S Pulaski St

15 Filed ..... 19 ..... Robert E. Harrison, Registrar

APR 19 1924

Burial Permit Gert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 19 24

17 I HEREBY CERTIFY, That I attended deceased from April 14, 19 24, to April 17, 19 24.

that I last saw her alive on April 17, 19 24.

and that death occurred, on the date stated above, at 1 35 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, Apoplexy

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis, Pulmonary Oedema (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Norbert E. Nebel, M. D.

4/17, 19 24 (Address) 215 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 21 19 24
20 UNDERTAKER	ADDRESS
Wm Ilies & S Sinsf	1737 N Pratt St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86038

CERTIFICATE OF DEATH.

D 86038

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis Bengl

(a) Residence No. 1 W. Barre St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1886

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town). (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Unknown

11- (Informant) Municipal Hospital Records

(Address)

15- 19 Registrar.

Robert F. Harrison,

APR 1 97924

Total Fruit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-17-24

17- I HEREBY CERTIFY, That I attended deceased from 4-15 1924 to 4-17 1924

that I last saw h~~e~~ alive on 4-17 1924

and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Chronic Nephritis

Cerebral Hemorrhage (Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) Claude A. Drace M. D.

4-17, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn DATE OF BURIAL. at April 24 1924

20-UNDERTAKER. S. E. Brown's Son ADDRESS 708 W Monty

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86039

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86039

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 918 Harford Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Treasa B. Pierce

(a) Residence No.... 918 Harford Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Colvild

6-DATE OF BIRTH (month, day and year) May 13, 1913

7-AGE, ... yrs. 11 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, George J. Price

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Sadie Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Mrs Sadie Price

(Address) 918 Harford Ave

15- Filed ..... 19.. ROBERT E. HARRISON, Jr., Registrar.

APR 1 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17-24

17- I HEREBY CERTIFY, That I attended deceased from March 19, 24, to April 17, 24, that I last saw h... alive on April 17, 24, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. 1 mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Farinacci, M. D.

4/19, 19 24 (Address) 109 S Milton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Bonnie Brae	April 19 1924
20-UNDERTAKER.	**ADDRESS**
Edmund W. Coughlin	824 E. Eager St.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86040

25-001

D 86040

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. 2312 East North Ave St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorris Catherine Vahle

(Residence in Baltimore: No. 2312 E. North Ave St.; yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word): Single

6-DATE OF BIRTH: March 13, 1923. (Month) (Day) (Year)

7-AGE: 1 yrs. 1 mos. 5 ds.
If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Ernest Christian Vahle
11-BIRTHPLACE OF FATHER (State or Country): Baltimore Md
12-MAIDEN NAME OF MOTHER: Ada Catherine Madden
13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs. Ernest C. Vahle
(Address): 2312 E. North Ave

15-

Filed ..... 191.. E. J. Harrison
Registrar.

PR 1 91924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 16 1924, to April 18 1924, that I saw her alive on April 18 1924, and that death occurred, on the date stated above, at 6.05 A.M.

The CAUSE OF DEATH* was as follows:

Chicken Pox

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 1 ds.

(Signed) Albert Olsenberg M.D.

April 18, 1924. (Address) 2007 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Carmel — DATE OF BURIAL, April 19, 1924

20-UNDERTAKER R. Deemann — ADDRESS 328 Broadway

Cor.—1-12-23—M&T—100 Bks.

D 86041

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86041

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W Mulberry St ST., 17 WARD)

2-FULL NAME Clarence Fazel

(a) RESIDENCE NO 702 W Mulberry St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Fona Fazel

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Suffolk Va
(State or country)

PARENTS

10 NAME OF FATHER Wesley Fazel

11 BIRTHPLACE OF FATHER (City or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Fona Fazel
(Address) 702 W Mulberry St

15 [illegible] 192 Registrar Robert E. Harrison

APR 7 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

From Ulcer of the Duodenum Perforation of the Heart

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W K Gorsuch M. D.
(Coroner.)

4-17, 192 4 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Suffolk Va	Apr. 19 192 4
20 UNDERTAKER Samuel Wesley	ADDRESS 1128 Bank St

INSTRUCTIONS

This CERTIFICATE OF DEATH is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86042

CERTIFICATE OF DEATH.

101-001

D 86042

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1015 N Strieker ST., 16 WARD)

2-FULL NAME Josephine Williams

(a) RESIDENCE NO. 1015 N Stricker ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Williams

6 DATE OF BIRTH (month, day, and year) Dec. 1879

7 AGE	Years	Months	Days
	45	3	

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West river Md

PARENTS

10 NAME OF FATHER John Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Betty Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph Williams

(Address) 1015 N Stricker St

15 Filed ..... 19 Robert P. Harrison, Registrar

APR 19 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1924, to April 16, 1924, that I last saw her alive on April 16, 1924 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard S French, M. D.

4/17, 1924 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4/19 1924

20 UNDERTAKER Samuel Pkinsley

ADDRESS 1338 Dallas

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86043 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward) 78

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... George Brown

(a) Residence No. 546 W Preston St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male | 4-COLOR OR RACE, Black | 5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 48 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)... 040

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Dan'l Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Dinah Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant)... Dand Eastern

(Address)... 916 Pa ave

15- Filed ... 192... Robert F. Hartman Registrar.

APR 1 1924 Assist Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/16/24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 25 1924 to April 16, 1924

that I last saw him alive on April 16, 1924

and that death occurred, on the date stated above, at 8-30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Carcinoma Obliterans

of Gangrene - Left Leg

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Epilepsy

(Duration) 12 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/7/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
MT Auburn Cem	4-20 1924
20-UNDERTAKER. Dand Eastern	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86044 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 31 D 86044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. ..... Municipal Tuberculosis Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvin Smith

(a) Residence No. 1101 McCulloh st. St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not given

6-DATE OF BIRTH (month, day and year): 1895

7-AGE. 29 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown
(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS.
10-NAME OF FATHER: Seth Smith
11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

11- (Informant) Hospital Records
(Address) M.T.H.

15- Filed ..... Robert P. Harrison, Registrar.

PR 1 91924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr. 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 10 19 24 to Apr. 17 19 24
that I last saw h. im alive on Apr. 17 19 24
and that death occurred, on the date stated above, at 7.15 A.M.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Sputum

(Signed) L. A. Kelly M. D
4-17-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-21 19 24
20-UNDERTAKER, Daniel Easton	ADDRESS 916 Pa ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D. 86045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 86045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Argyle Ave ST., 14 WARD)

2-FULL NAME Elizabeth Hughes

(a) RESIDENCE NO. 1616 Argyle Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hughes

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Sally Randall

13 BIRTHPLACE OF MOTHER (city or town) A-A. Co (State or country) Md.

14 Informant Julius Green

(Address) 702 Woodyear Pl

15 Filed ..... 19 ..... Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 1924

17

I HEREBY CERTIFY, That I attended deceased (rom Jan 17, 1924, to Apr 16, 1924,

that I last saw her alive on Apr 16, 1924,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 0r 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Fray, M. D.

4/17, 1924 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL Apr 19 1924

20 UNDERTAKER Sam'l W. Chase ADDRESS 1400 Mosher

APR 19 1924

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86046

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Lemmon Av ST. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Orpheus Owens

(a) RESIDENCE. NO. 822 Lemmon Av ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Owens

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
35	1889	Jan	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoefixer 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bolt Iron Mfg

9 BIRTHPLACE (city or town) (State or country) Fort Allen

PARENTS

10 NAME OF FATHER King Orpheus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fort Lauderdale

12 MAIDEN NAME OF MOTHER Cornelia Ostend

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Annie F Owens

(Address) 1103 Myrtle ave

15 Filed ..... 19 ..... Robert E. Harrison, Registrar

PR 1 91924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1924

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to April 15, 1924, that I last saw him alive on April 15, 1924, and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows: Cardiac Disease Endocarditis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) Charles V. Hinkel, M. D.

1924 (Address) 722 S Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	April 20 1924
20 UNDERTAKER	ADDRESS
John H Owens	538 Milton

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D 86047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86047

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1609 N. Bond St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Lewis

(a) Residence No. 1609 N. Bond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Lewis

6-DATE OF BIRTH (month, day and year) Sept 18, 1866

7-AGE. 57 yrs. 6 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry A. Echse

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Barbara Eberle

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) John Lewis

(Address) 1609 N. Bond St.

15- Filed APR 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1920, to April 16 1924,

that I last saw h.. alive on April 16 1924,

and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of 1920

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D.

April 17 1924 (Address) 2005 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
[illegible] Cemetery	April 21 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander Sons	1710 Pleasant St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86048

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hosp.

CITY OF BALTIMORE: (No 1112 N. Mount ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elsie Moore

(a) RESIDENCE No. 1732 Darley ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. [illegible] (deceased)

6 DATE OF BIRTH (month, day, and year) July 17, 1876

7 AGE Years 48 Months Days If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring business

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER (?) Einloft

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Elsie~~ (?) Einloft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis A. Kenner (Son)
(Address)

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1924 to April 18, 1924 that I last saw h.w alive on April 18, 1924 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) several years

CONTRIBUTORY (Secondary) Rupture of vessel 4 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. A. Sugarman M. D.

, 19 (Address) Colonial Hosp. 1112 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL April 21 1924

20 UNDERTAKER L. Sander Sons ADDRESS 1710 Pratt St

PR 1 91924

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.E.R.S.—400 Bks.

D 86049

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 728 E. Biddle St., 17 Ward) 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. J. Henry Becker

(a) Residence No. 728 E. Biddle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) July 10, 1866

7-AGE. 57 yrs. 9 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). None
(c) Name of employer. None

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.
10-NAME OF FATHER. Henry Becker
11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country). Germany
12-MAIDEN NAME OF MOTHER. Mary Dank
13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country). Germany

14- (Informant) Bertha E. Becker
(Address) 728 E. Biddle St.

15- Filed ..... 1924 ..... Registrar.

APR 9 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from ~~about~~ April 1, 1924, to April 16, 1924, that I last saw him alive on April 16, 1924, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac Sympt. of arteriosclerosis (Duration) ....yrs. ....mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D

4/18, 1924 (Address) 1014 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	April 19, 1924
20-UNDERTAKER.	**ADDRESS**
H. Sander & Sons	1710 Fleet St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

LAW B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86050

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86050

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2009 Bank St., 2nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary May Crawford

(a) Residence No. 2009 Bank St., 2nd Ward

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 5th 1902

7-AGE, 21 yrs. 11 mos. 12 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) City
(State or Country),

PARENTS.

10-NAME OF FATHER, George Crawford

11-BIRTHPLACE OF FATHER (city or town) City
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Kahlert

13-BIRTHPLACE OF MOTHER (city or town) City
(State or Country),

14-

(Informant) Mrs. George Crawford

(Address) 2009 Bank St

15-

Filed ..... 192. Robert P. Harrison, Registrar.

APR 19 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 17 - 24

17- I HEREBY CERTIFY, That I attended deceased from March - 27, 1924, to April 17, 1924,

that I last saw h.r alive on April 17, 1924,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

a Sub Acute Nephritis cm Cardiac Hypertrophy

b Hernia Convalescem -

(Duration) a = yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) b = yrs. — mos. 1- ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Dr. A. Barnes, M. D.

1/4/, 1924 (Address) 1858 Bloom

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, April 21st 1924

20-UNDERTAKER, Peter Nicolauszoo — ADDRESS Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86051

CERTIFICATE OF DEATH.

Registered No. 74

1-PLACE OF DEATH

City of BALTIMORE: (No. 3205 Eastern Ave St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Keiser

(a) Residence No. 3205 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? 67 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Peter Keiser

6-DATE OF BIRTH (month, day and year) Feb 17th 1857

7-AGE, 67 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, John Bemesderfer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna M. Schwab

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Morgan

(Address) 3205 Eastern Ave

15- Filed ..... 192.... Robert F. Carroll, Registrar.

Burial Permit Clerk.

PR 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 16 24

17- I HEREBY CERTIFY, That I attended deceased from April 12 19 24, to April 16 19 24,

that I last saw h...alive on April 16 19 24,

and that death occurred, on the date stated above, at 4.5 m.

The CAUSE OF DEATH* was as follows:

Asphyxia Left Hemiplegia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Bartlett, M. D.

, 19 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL, April 17 1924

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2010 Eastern Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS ... instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86052

HEALTH DEPARTMENT—CITY OF BALTIMORE D 86052

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 N. Carey ST., 19 WARD)

2-FULL NAME Mary A O'Neill

(a) RESIDENCE NO. 234 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) May 30-1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) West moreland Co Pa

PARENTS

10 NAME OF FATHER Alvin Chickering

11 BIRTHPLACE OF FATHER (city or town) (State or country) N H

12 MAIDEN NAME OF MOTHER Eunice Gleason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N H

14 Informant Eunice O'Neill
(Address) 234 N Carey st

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to April 17, 1924.
that I last saw h. W alive on April 17, 1924
and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Paralysis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Age

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of .....
Was there an autopsy? No What test confirmed diagnosis? General Symptoms
(Signed) John V Crans M. D.
19 (Address) 10 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa

DATE OF BURIAL April 21 1924

20 UNDERTAKER George J Smith

ADDRESS 1532 Hollins

APR 1 91924

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86053

CERTIFICATE OF DEATH.

101-001

D 86053

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 850 St. Peter ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Alma O. A. Merriken

(Residence in Baltimore: No. 850 St. Peter St.; 32 yrs., 6 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, September 26, 1891.
(Month) (Day) (Year)

7-AGE, 32 yrs. 6 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Carl E. Krumbach

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Anna Knoll

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leah Lembeck

(Address) 530 E. 32nd St.

15- Filed 191.... Robert P. Harris, Registrar.

PR 1 91924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 18, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 7th 1924, to April 18th 1924, that I saw h[illegible] alive on April 17th 1924, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia & Pleurisy

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. mos. 1 ds.

(Signed) J. B. Culbertson M. D.

4/18/, 1924 (Address) 1901 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Western Country

19-PLACE OF BURIAL OR REMOVAL, ~~Loudon Park Cemetery~~ DATE OF BURIAL, 4/18/24, 191...

20-UNDERTAKER Geo Lembeck & Son ADDRESS 64 N. Mount St.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86054

CERTIFICATE OF DEATH.

146 D 86054

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christine M. Delker

(a) RESIDENCE NO. Edmondson ave and Glenwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Delker

6 DATE OF BIRTH (month, day, and year) Apr 27-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

037

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lewis Rossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margt Seippel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

FR 1 91924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1924, to April 17, 1924, that I last saw her alive on April 17, 1924, and that death occurred, on the date stated above, at 7.00 p.m.

The CAUSE OF DEATH* was as follows:

General peritonitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Puerperal infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) E. E. Duncan, M. D.

4/17. 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 19 24
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	Baltimore Md

Reg. No. 1.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86055

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86055

88

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 N. Caroline St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas W Hook

(a) Residence No. 1100 N. Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Selmar E. Hook

6-DATE OF BIRTH (month, day and year) Nov 3 1883

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chief Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) City Hall

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Richard E Hook

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Sarah Davidson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Selmar E Hook

(Address) 1100 N Caroline

15- Robert F. Harrison, M. D. Registrar.

APR 19 1924

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17 1924

17- I HEREBY CERTIFY, That I attended deceased from March 9 1924, to April 17 1924, that I last saw him alive on April 17 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute Septic Endocarditis and Myocarditis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert Armistead, M. D.

April 18, 1924 (Address) 1111 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Dallstown	Apr 19, 1924
20-UNDERTAKER.	ADDRESS
Robt Stewart Son	N. Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1824 N. Chester St., 8 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Lucas

(a) Residence No. 1824 N. Chester St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John E Lucas

6-DATE OF BIRTH (month, day and year) May 30 1855

7-AGE 68 yrs. 10 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, Mary Ann Thomas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), St Marys Co Md

14- (Informant) John E. Lucas

(Address) 1824 N. Chester St

15- Filed 19 Robert P. Harrison, Registrar.

APR 1 1924

413 N Washington St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17-1924

17- I HEREBY CERTIFY, That I attended deceased from April 4 1924 to April 17 1924

that I last saw h. alive on April 16 1924

and that death occurred, on the date stated above, at 12 20 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Leary M. D.

4/16, 1924 (Address) 413 N Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cem	Apr 19, 1924
20-UNDERTAKER,	ADDRESS
John O. Mitchell	1201 W Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86057

CERTIFICATE OF DEATH.

129 D 86057

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 N. Carrollton ave 18 ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Jane Wells

(a) Residence No. 15 N. Carrollton St., ...Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Nicholas B Wells

6-DATE OF BIRTH (month, day and year)

7-AGE: 84 yrs. ...mos. ...ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Richmond Va

PARENTS.

10-NAME OF FATHER: Jessie Barry

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Richmond Va

12-MAIDEN NAME OF MOTHER: Sarah Minor

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Richmond Va

14- (Informant): Sadie Wells

(Address): 15 N. Carrollton ave

15- Filed ... 19... Robert F. Harrison, Registrar.

Burial Permit Clerk.

APR 19 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 18-1924

17- I HEREBY CERTIFY, That I attended deceased from 10/22 19 24 to 4/18/24 19...

that I last saw her alive on 4/10/24 19...

and that death occurred, on the date stated above, at 9:10 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chr. Inter. Nephritis

(Duration) 3 yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

4/19, 1924 (Address) 410 W Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Apr 21 19 24

20-UNDERTAKER: John O Mitchell — ADDRESS: 1211 Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86058

HEALTH DEPARTMENT—CITY OF BALTIMORE

105

D 86058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 604 Bennett Place St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edwin Webster Bennett

(a) Residence No. 604 Bennett Place St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Emma A. Bennett

6-DATE OF BIRTH (month, day and year) March 1. 1869

7-AGE, 55 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Plumber

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... Bennett Bros

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, David J. Bennett

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER, Charity A. James

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Frederick Md

14- (Informant)..Emma A. Bennett

(Address)..604 Bennett Place.....

15- Filed..... Robert P. Harrison Registrar.

APR 19 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) APR 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 23rd, 1923, to April 18, 1924, that I last saw h.. alive on April 18, 1924, and that death occurred, on the date stated above, at 4.05 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

Not Tubercular.

(Duration) 1 yrs. 1 mos. 26 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs..... mos..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Robt J. Murray M. D., M. D.

APR 19 1924 (Address) 5101 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~, London Park

DATE OF BURIAL, APR 21 1924

20-UNDERTAKER, Geo W Little

ADDRESS 2700 [illegible] AVE.

U. S. WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86059

CERTIFICATE OF DEATH.

100-001 D 86059

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2051 Hanover St. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward K Weitzell

(a) RESIDENCE NO. 2051 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 30 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	18	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Milton Chanie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Round Bay A A Co Md

12 MAIDEN NAME OF MOTHER Bessie A Weitzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs Chas A Weitzell 2051 Hanover st

15 9 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1— 1924, to April 18 1924, that I last saw him alive on April 18 1924, and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E K Weitzell, M. D.

4/19/24 (Address) 1207 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL April 19 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Light

Burial Permit Clerk

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

R 1

Spec.—1-10-21—M&T—1500 Bks.

D 86060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86060

CERTIFICATE OF DEATH.

X 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. St.) 9 WARD)

REGISTERED NO. /

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Snowden

(a) RESIDENCE NO. Pikesville Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particuiar kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Snowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Hardisty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Fischer - Laurel. Md.
(Address)

15 Robert P. Harrison Registrar

R 1 9 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18th 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 28th, 1924, to Apr 18th, 1924, that I last saw him alive on Apr 18th, 1924, and that death occurred, on the date stated above, at 8:30a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach (pyloric end).

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastases to liver, & pancreas (duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam.

(Signed) A C Manninger, M. D.

4-18, 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem. Laurel. Md.	4/20 1924
20 UNDERTAKER	ADDRESS
Ex B Hale	115 E. West St. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86061

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86061

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3148 Rosewood ST., 8 WARD)

2-FULL NAME Mary E. Burdette

(a) RESIDENCE No. 3148 Rosewood ST., 8th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Burdette

6 DATE OF BIRTH (month, day, and year) Oct 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lewis Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Stella Storey

(Address) 2145 Druid Park Drive

15 Filed ..... 19 Robert F. Harrison, Registrar

APR 19 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 6 1924, 19....,

that I last saw h... alive on ....., 19....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Metrd Hemorrhage

(duration) 15 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptomatic

(Signed) Henry Pennell, M. D.

4/18, 1924 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cem.	April 21 1924
20 UNDERTAKER	ADDRESS
Eichelman Bros	1034 Fairmount

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86062

CERTIFICATE OF DEATH.

D 86062

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

2-FULL NAME Margaret Strawbridge

(a) RESIDENCE NO. Parkton Md. ST., WARD Parkton Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. M. Strawbridge

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Maryland General Hospital Baltimore Md.

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

APR 19 1924

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924.

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1924, to April 19, 1924.

that I last saw her alive on April 19, 1924

and that death occurred, on the date stated above, at 8.10 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Duodenal Ulcer

Chronic Appendicitis

Ovarian cyst

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Toxic Psychosis

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of March 25

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operation

(Sign) James Hulst Wiedman M. D.

(Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Freedom Pa

DATE OF BURIAL 4/19 1924

20 UNDERTAKER CHENOWETH & SON

ADDRESS 3617 CHESTNUT AVE

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICI CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Oc TION is very important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Blks.

D 86063

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 86063

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 26 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig Metzler

(a) RESIDENCE NO. Bay View Asylum St., Ward

(Usual place of abode) (If noo-resident give city or town aod State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Friedrich Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henerietta Geiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records
(Address)

15 APR 1 1924 . 19 Robert E. Miller Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18 1924

17

I HEREBY CERTIFY, That I attended deceased from 3-24 1922 to 4-18 1924

that I last saw him alive on 4-18 1924

and that death occurred, on the date stated above, at 12.25 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude 9. Bruce M. D.

4-18 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	June 21 1924
20 UNDERTAKER	ADDRESS
Kendell Dyer & Son	372 N

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... shou... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1 X 89

D 86064

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Nicol.

(a) RESIDENCE NO. 1466 N Monroe ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. John Nicol

6 DATE OF BIRTH (month, day, and year) Feb 13 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 071

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Albert Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records (Address)

15 APR 20 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/1924

17 I HEREBY CERTIFY, That I attended deceased from 4/8/24 19 ..., to 4/18/24 19 ...,

that I last saw h alive on 4/18/24 19 ...,

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Arteriosclerosis Fibrillation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gellen, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manassas Va	4/23/24
UNDERTAKER	ADDRESS
Geo A Farley & Sons	Baltimore Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86065 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86065

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Effie Hall

(a) RESIDENCE No. 1930 McCulloh St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
✓	3	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lloyd Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Sarah Briscoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 APR 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-24

17

I HEREBY CERTIFY, That I attended deceased from 4-18-24 19.. to 4-19-24 19..

that I last saw her alive on 4-19-24 19..

and that death occurred, on the date stated above, at 1.50 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria

Tonsillar & Pharyngeal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Culture

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Apr 9 1924
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	467 N. Gordon St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86066

CERTIFICATE OF DEATH.

129 D 86066

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S Furrow ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Eber

(a) RESIDENCE. NO. 205 S Furrow ST., 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1849 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Hartman Daughter

(Address) 205 S Furrow St.

APR 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1924, to Apr 19, 1924, that I last saw h— alive on Apr 18, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Chr Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James K Adelsberger M. D.

4/19 1924 (Address) 1724 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Apr 21 1924
20 UNDERTAKER	ADDRESS
Mr-Mrs Ch S Fink	1737 N Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86067

CERTIFICATE OF DEATH.

49 D 86067

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rutland & Monument Sts Sinai Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Blondheim

(a) RESIDENCE NO. 2329 Mondawmin ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Clara Blondheim

6 DATE OF BIRTH (month, day, and year) June 19 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Merchant Balto

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Herz Blondheim

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Goodman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Clara Blondheim
(Address) 2329 Mondawmin Ave

15 Filed APR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1924, to April 19, 1924, that I last saw him alive on April 19, 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

~~Grippe~~ Lobar pneumonia (1st)
Myocardial failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) H. Adler Jonas Heimer M. D.

19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem

DATE OF BURIAL 4/21/1924

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 86068

D 86068

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3423 Roland Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Powers

(a) Residence No. 3423 Roland Ave. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth J. Powers

6-DATE OF BIRTH (month, day and year) Mar. 9th. 1849

7-AGE. 75 yrs. 1 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER John Powers

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Bridget Welsh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- Miss Agnes Powers. (Informant)

3423 Roland Ave. (Address)

15- APR 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17/ 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to April 17 1924

that I last saw h[illegible] alive on April 17 1924

and that death occurred, on the date stated above, at 7.45 A m.

The CAUSE OF DEATH* was as follows: Cazenoud Gall Bloder & Liver Cirrhosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) debility due to age

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no in reference

What test confirmed diagnosis? Jaundice + Moss

(Signed) S. K. Wauf M. D

4/19 1924 (Address) 865 W. 36th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 4/21 1924

20-UNDERTAKER. C.F.Evans & Son, Inc.

ADDRESS 118 W. Mt Royal Ave.

N. B.—WHITE PENCIL, WITH ONE LEADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86069 **CERTIFICATE OF DEATH.** 129 D 86069

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 643 N Calhoun St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Susie E Mumbert

(a) Residence No. 643 N Calhoun St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~ Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James H Mumbert

6-DATE OF BIRTH (month, day and year) Sept 7 1848

7-AGE, 76 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at home

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Va
(State or Country),

PARENTS.

10-NAME OF FATHER William Cuttlefield

11-BIRTHPLACE OF FATHER (city or town)..... Va
(State or Country),

12-MAIDEN NAME OF MOTHER Ellen Lyon

13-BIRTHPLACE OF MOTHER (city or town)..... Va
(State or Country),

14- (Informant) Marion A Mumbert
(Address) 643 N. Calhoun St

15- APR 20 1924 ROBERT R. KRAUTER, Registrar.

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19 24

17- I HEREBY CERTIFY, That I attended deceased from Aug, 1923, to April, 1924, that I last saw h.. alive on April 1, 1924, and that death occurred, on the date stated above, at 10 AM. The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Fernando R. Nichols, M. D.

, 19 (Address) 404 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park	April 20, 1924
UNDERTAKER,	ADDRESS
William Carlson & Nathan	

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Nichols 740 N Charles

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86070

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1207 Riverside Ave ST. 74 WARD)

2-FULL NAME Joseph Edward Noonan

(a) RESIDENCE. No. 1207 Riverside Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 8 1922

7 AGE — Years: 1 — Months: — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robert E Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Marie H Koster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Robert E Norman

(Address): 107 Riverside Ave

15 Filed APR 20 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.19.24 19

17 I HEREBY CERTIFY, That I attended deceased from 4.5.24 19 ... to 4.19.24 19 ...

that I last saw him alive on 4.19.24 19 ...

and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ... yrs. ... mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Edward Norris M. D.

4.19.24 19 (Address) 107 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co	4/21 1924
20 UNDERTAKER: E & B Hasle	ADDRESS: 110 E Preston St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86071

CERTIFICATE OF DEATH.

101-001 ✓ D 86071

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3915 Forrest Park ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Morris Keyser

(a) Residence No. 3915 Forrest Park ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 20 1909

7-AGE. 14 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Osoe Keyser

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Mollie Keyser

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 Eutaw St

15- Filed APR 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-19-24

17- I HEREBY CERTIFY, That I attended deceased from 3/31, 1924, to 4/19, 1924, that I last saw h[illegible] alive on 4/18, 1924, and that death occurred, on the date stated above, at 6.9 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) — yrs. — mos. 21 ds.

CONTRIBUTORY (Secondary) Chr Mitral & Aortic Endocarditis (Duration) 6 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Dan Deaver M. D.

4/20, 1924 (Address) 122 W. Lee St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Wehrenrook Road	4/21, 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis 1439	Eutaw

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86072

CERTIFICATE OF DEATH.

90 D 86072

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Rosenberg

(a) RESIDENCE NO. 115 Gaisguith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Rosenberg

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Old age

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Louis 1439 E Baltimore St

15 APR 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1924, to April 16, 1924, that I last saw her alive on April 16, 1924, and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm H Barling, M. D.

4/19 1924 (Address) 710 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Herring Run — DATE OF BURIAL 4/21 1924

20 UNDERTAKER Jack Louis — ADDRESS 1439 E Balto St

Cor.—1-12-23—M&T—100 Bks.

Garrison

D86073 . HEALTH DEPARTMENT—CITY OF BALTIMORE D86073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 832 Rutherford ST., 18 WARD)

2-FULL NAME Rosa ann Garrison

(a) RESIDENCE No. 832 Rutherford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colo	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Patrick Ficketts

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Clutoron

13 BIRTHPLACE OF MOTHER (city or town) Abyoron.
(State or country)

14 Informant Horace Garrison
(Address) 832 Rutherford

15 Filed APR 20 1924 (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 17th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. Don't know mos. ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

(Signed) J W Funnel, M. D.
(Coroner.)

4-19, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Clutoron Cem — DATE OF BURIAL April 1924

20 UNDERTAKER Samuel Hensley — ADDRESS 1114 Eddy St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 86074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 Eager. ST., 7 WARD)

REGISTERED NO. 181 D 86074

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Kreigel

(a) RESIDENCE NO. 1503 Eager ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of George Kreigel

6 DATE OF BIRTH (month, day, and year) Dec. 3, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) ..... do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Herold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Bergmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry F. Kramer

(Address) 1503 E. Eager St

15 APR 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy 1 d. Coma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

(Signed) Jos Collins Blake, M. D.

(Coroner.)

4/19, 192 (Address) 1432 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	4/21 1924
20 UNDERTAKER Burkert & Zirkler	ADDRESS 1739 Eager

Caution should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Blks.

D 86075

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 D 86075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 704 S. Decker Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Barbara E. Johns

(a) Residence No. 704 S. Decker ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George G. Johns

6-DATE OF BIRTH (month, day and year) June 25-1890

7-AGE.	If LESS than 1 day,
33 yrs. 9 mos. 7 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto, Md.

PARENTS.

10-NAME OF FATHER. Wm. Hopf.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto, Md.

12-MAIDEN NAME OF MOTHER. Barbara E. Boehm

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto, Md

14- (Informant) George G. Johns

(Address) 704 S. Decker ave

15- Filed APR 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 18-1924

17- I HEREBY CERTIFY, That I attended deceased from March 28, 19.24., to April 18, 19.24.

that I last saw her alive on April 17, 19.24.

and that death occurred, on the date stated above, at 12 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Colloyne

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Erisipelas - following endo - carditis for Rheumatism (Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. W. Jones, M. D.

4/18, 1924 (Address) 1013 S. Ellwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Oaklawn	4/21, 19.24
20-UNDERTAKER. Penkler & Penkler	ADDRESS 1739 Eager

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D 86076

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 Cookair St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Joseph Brown

(a) Residence No. 1410 Cookair St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced. (Write the word.)
male	white	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 21 1923

7-AGE.	If LESS than 1 day,
...yrs. 7 mos. 29 ds.	...hrs. or...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant.

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore,
(State or Country).

PARENTS.

10-NAME OF FATHER, Alexander Brown

11-BIRTHPLACE OF FATHER (city or town)... Baltimore
(State or Country). Md.

12-MAIDEN NAME OF MOTHER, Cecelia Smolinski

13-BIRTHPLACE OF MOTHER (city or town)... Baltimore
(State or Country). Md

14- (Informant) Alexander Brown

(Address) 1410 Cookair St.

15- Filed APR 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 19th 1924

17- I HEREBY CERTIFY, That I attended deceased from april 17 1924 to april 19 1924

that I last saw h. alive on april 18 1924

and that death occurred, on the date stated above, at 10 30a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Uncomplicated

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Stevens M. D

4/19, 1924 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross Cem	4-21 19 24
20-UNDERTAKER Chas. P. Sturm	ADDRESS 1501 E Fort Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Skuber

D 86077 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 29 D 86077

1-PLACE OF DEATH Maryland General Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Charles Skuber

(a) RESIDENCE NO. 1415 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Skuber.

6 DATE OF BIRTH (month, day, and year) July 7-1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Charles H. Skuber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Simis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Mary Skuber 1415 Patapsco

15 Filed APR 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 17, 1924, to Apr 18, 1924.

that I last saw him alive on Apr 18, 1924.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tetanus

Wound of ankle on 4/10/24

(duration) ? yrs. mos ? ds.

CONTRIBUTORY (Secondary) Pneumonia dbl

(duration) yrs. mos. 36 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Apr 17-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Jno A Tompkins M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	4/21 1924
20 UNDERTAKER	ADDRESS
I. Frew McCauley	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86078

91-002 ✓

D 86078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 6338 Park Hts ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. J. Frackmann

(a) RESIDENCE. NO. 6338 Park Hts ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 29-1849

7 AGE	Years	Months	Days
	74	4	21

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John. Frackman

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Bode

13 BIRTHPLACE OF MOTHER (city or town) Germa
(State or country)

14 Informant Mrs. C. Struth
(Address) 6338 Pk Hts ave

15 Filed APR 20 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to April 18, 1924, that I last saw him alive on April 17, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P. H. Cleveland M. D.

4/18/24 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	4/22 1924
20 UNDERTAKER	ADDRESS
L. Frew McCulley	130 E. Fort

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86079

44 D 86079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 345 W. 21st ST. 13 WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Callery.

(a) RESIDENCE NO. 345 W. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorcilla Callery.

6 DATE OF BIRTH (month, day, and year) Aug. 18-1865

7 AGE Years 58 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Long Green Md.

PARENTS

10 NAME OF FATHER Patrick Callery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Dorcilla Callery.

(Address) 345 W. 21st St.

15 APR 20 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923, to Apr 18, 1924.

that I last saw him alive on Apr 18, 1924.

and that death occurred, on the date stated above, at 130 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus.

Onset & my knowledge 7 mos

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & Microscopical Exam.

(Signed) Jno A Pleasants M. D.

19 (Address) 1025 Mad. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loyola Cathedral — DATE OF BURIAL: Apr 22 1924

20 UNDERTAKER: George L. Schmidt — ADDRESS: 2101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86080

100-001 ✓

D 86080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2022 Wilhelm St., 70 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Lena Hefner

(a) Residence No... 2022 Wilhelm St., Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F. Hefner

6-DATE OF BIRTH (month, day and year) Aug 7 1863

7-AGE. 60 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... Wife

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, John Steter

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Madeline Herring

13-BIRTHPLACE OF MOTHER (city or town)..... Germany
(State or Country),

11- (Informant)..... Chas Hefner

(Address)..... 2023 N. Henry St

13- Filed APR 2 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to April 18, 1924, that I last saw h.e alive on April 18, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) M. D.

4/19, 1924 (Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral — DATE OF BURIAL, Apr. 21, 1924

20-UNDERTAKER. George L. Schwab — ADDRESS Frederick, Md.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86081

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86081

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2209 E Pratt ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Veronica Polaczewska

(a) RESIDENCE NO. 2209 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Whit	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Polaczewska

6 DATE OF BIRTH (month, day, and year) Sept. 17. 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work. 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stephen Kendryna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Polek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Polaczewska

(Address) 2209 E Pratt St

APR 2 0 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from 15th December, 1923, to April 18, 1924,

that I last saw her alive on April 17th, 1924,

and that death occurred, on the date stated above, at 4 20 ~~P~~ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Fell down Stairs (accidental)

(duration) yrs. 5 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Jod, M. D.

4/18, 1924 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	4/21 1924
UNDERTAKER William Gackowski	ADDRESS 418 Eastern Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86082

CERTIFICATE OF DEATH.

129

D 86082

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 E. Balto St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Deimel

(a) Residence No. 1409 E. Balto St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenz Deimel

6-DATE OF BIRTH (month, day and year) Sept 5/44

7-AGE. 74 yrs. 7 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER. John Aulbach

11-BIRTHPLACE OF FATHER (city or town) Ger. (State or Country),

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) Ger. (State or Country),

14- (Informant) Mrs Julius H. Thiele

(Address) 1409 E. Balto, Md.

15- Filed APR 20 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/18/24

17- I HEREBY CERTIFY, That I attended deceased from March 3, 1924 to April 18, 1924 that I last saw h. alive on " " 1924 and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

Did not Know (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Alb. & Albuminuria

(Signed) George H. Hartman M. D

Apr. 19. 1924 (Address) 2214 Maryland Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Cem. DATE OF BURIAL. 4/21, 1924

20-UNDERTAKER. Philip Henry ADDRESS 2006 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86083

CERTIFICATE OF DEATH.

X 111-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Trouh Howard.

(a) RESIDENCE NO. 731 Piedmont Ave ST., WARD Atlanta Georgia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Trouh Howard.

6 DATE OF BIRTH (month, day, and year) April 13 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Georgia
(State or country)

PARENTS

10 NAME OF FATHER Chesley Howard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Caroline Shackelford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Hospital Records.
(Address)

15 Filed APR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1924, to April 20, 1924,

that I last saw him alive on April 20, 1924,

and that death occurred, on the date stated above, at 8.50 a.m.

The CAUSE OF DEATH* was as follows:

Old gastric ulcer giving some obstruction
Operated upon. Developed a
post-operative Bronchial Pneumonia.

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Atlanta Georgia

Did an operation precede death? yes Date of April 16, 1924

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Raymond L Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Atlanta Ga.

DATE OF BURIAL 4-20 1924

UNDERTAKER Evans & Jenkins Morse Co

ADDRESS Whitehall & Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86084

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE, (No. 2218 Monroe St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Elizabeth Hyerman Dryden

(a) Residence No. 2218 Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced: (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Married Steph[illegible]

6-DATE OF BIRTH (month, day and year): Aug 7 1903

7-AGE: 21 yrs. 8 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Home

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Henry C Hyerman

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Margt C Crawford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md Co

14 (Informant): Mary E Hyerman

(Address): 2218 Monroe

15- Filed APR 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4/18/24

17- I HEREBY CERTIFY, That I attended deceased from 11/23/23 19.. to 4/18/24 19..

that I last saw h.. alive on 4/18/24 19..,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) mos. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 1923 St Joseph Hosp

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard Stern M. D

(Address) 4 E Lexington St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	April 19 24
UNDERTAKER	ADDRESS
W. Fielder Son	Matthews

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 86085 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 11-09 D 86085

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Roland Ave & St Georges Rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Baer Candler

(a) Residence No. Roland Ave & St Georges Rd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male ~~Female~~ | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Kepler Melinda Candler

6-DATE OF BIRTH (month, day and year) July 7 1849

7-AGE. 74 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER, John Candler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Cecelia E. Wetzhanner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

11- (Informant) Mrs Chas E. Bond
(Address) Roland Ave & St Georges Rd

ROBERT R. KRAMER

13- APR 20 1924 Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 18 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15 1924 to April 18 1924.

that I last saw h.. alive on April 18 1924

and that death occurred, on the date stated above, at 11 50 P m.

The CAUSE OF DEATH* was as follows:

La Grippe (Pauline hemorrhage)

(Duration) yrs. 10 mos. ds

CONTRIBUTORY (Secondary) Senility (75 yrs)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. McNemeson, M. D

, 19 (Address) 316 Hurston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park | DATE OF BURIAL. Apr 22 24

20-UNDERTAKER. Wm J Pickerdon | ADDRESS North & Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86086

CERTIFICATE OF DEATH.

90 ✓ D 86086

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2326 Arunnah Ave ..... St., 16 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Irving Buck .....

(a) Residence No. 2326 Arunnah Ave. ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella S. Buck

6-DATE OF BIRTH (month, day and year) Aug. 28. 1853

7-AGE.	If LESS than 1 day.
70 yrs. 7 mos. 20 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cabinet Maker

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 014

(c) Name of employer American Seating Co.

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, George W. Buck

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Virginia Irving

13-BIRTHPLACE OF MOTHER (city or town) Salusbury (State or Country). Md.

14-
(Informant) Ella S. Buck
(Address) 2326 Arunnah Ave.

15-
Filed APR 2 0 1924 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 29th 1923 to April 17th 1924, that I last saw him alive on April 17th 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Mitrial and Aortic Regurgitation

(Duration) 2 yrs. 6 mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herbert E. Zapf M. D.

M-19 1924 (Address) 3048 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
~~Loudon Park Cem.~~	4/21/24 19..
20-UNDERTAKER.	ADDRESS
Wm. J. Tickner & Sons	948 North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86087

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bowley's Lane near Franklin 21 ST., 76 WARD) Ave. Raspeburg

2-FULL NAME Hilda Lohisa Koppelmann

(a) RESIDENCE NO. Bowley Lane near Franklin ave. Raspeburg ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Infant

6 DATE OF BIRTH (month, day, and year) Feb. 12th 1924

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs or.....min.
	—	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER John L. Koppelman

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma M. Sietz

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant John L. Koppelman (Address) Raspeburg Md.

15 APR 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14th, 1924, to April 19th, 1924, that I last saw h[illegible] alive on April 19th, 1924, and that death occurred, on the date stated above, at 2.22 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) ..... yrs. ..... mos 1 ds. 5

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) [illegible] M. D.

(Address) 1501 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 21 1924
20 UNDERTAKER	ADDRESS
Fred'k Lasch & Sons	Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be written with indelible ink—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86088 ✓ D 86088

CERTIFICATE OF DEATH.

D 86088

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., COL. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Frederick Grimme

(a) RESIDENCE NO. 622 S. Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
V	2	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. Grimme

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ill.

12 MAIDEN NAME OF MOTHER Etel Marshall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Charles Grimme.
(Address) 622. S. Hanover st.

15 Filed APR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/24

17

I HEREBY CERTIFY, That I attended deceased from 4-11-24 19 , to 4-19-24 19 ,

that I last saw h alive on 4-19-24 , 19 ,

and that death occurred, on the date stated above, at 10⁵⁵ a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
Secondary to measles

(duration) yrs. mos. 9 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4/20/24

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford Ave

IMPORTANT; WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86089

CERTIFICATE OF DEATH.

89 D 86089

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Woodside Rd (St.) Chapel Gate Lane (Ward) Pimlico

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter D. White

(a) Residence No. Woodside Rd. (St.) Chapel Gate Lane Ward Pimlico

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 1 1866

7-AGE 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Daniel S White

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliz[illegible] Doll Annie B.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) W Va.

14- (Informant) Katherine M White

(Address) Woodside Rd

15- Filed APR 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1923 to April 1924, that I last saw him alive on April 10th 1924 and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Lucius M. Gray, M. D.

, 19 (Address) 1014 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Brigid Ridge Cem	April 21 1924
20-UNDERTAKER	ADDRESS
John O. Mitchell	220 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86090 — 129 — D 86090

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 4012 Kathland Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Elizabeth T. De Cock

(a) Residence No. 4012 Kathland Avenue St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gustave De Cock

6-DATE OF BIRTH (month, day and year) Jan. 28, 1850

7-AGE,	If LESS than 1 day,
74 yrs. 2 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.... None

(b) General nature of industry, business, or establishment in which employed (or employer)....

(c) Name of employer....

9-BIRTHPLACE (city or town).... Boston
(State or Country), Massachusetts

PARENTS.

10-NAME OF FATHER, John Talbott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country).

14- (Informant).... Frederick T. De Cock
(Address).... 4012 Kathland Ave.

15- APR 20 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 16, 1924, to April 18, 1924, that I last saw h[illegible] alive on April 18, 1924, and that death occurred, on the date stated above, at 7.35 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

?

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) — yrs. — mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Nu Date of —

Was there an autopsy? Nu —

What test confirmed diagnosis?

(Signed) Edward Novak, M. D.

4-19, 1924 (Address) 26 East Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Boston Mass	Apr 20, 1924
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 N. Eutaw St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86091

CERTIFICATE OF DEATH.

91-002 ✓ D 86091

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. German Aged Home ST. Baltimore and Payson Sts WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Fleisner.

(a) RESIDENCE. No. German Aged Home ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant German Aged Home Records.
(Address) Balto and Payson Sts.

15 APR 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1923, to April 18th 1924, that I last saw her alive on April 18th 1924, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John L Staff, M. D.

, 19 (Address) 1845 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Apr 21 24
20 UNDERTAKER Joseph L. Cook	ADDRESS 1223 E Balto St

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 86092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 49

D 86092

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 339 Bloom St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Doyle

(a) Residence No. 339 Bloom St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Belle H. Taylor

6-DATE OF BIRTH (month, day and year) Dec. 25, 1888

7-AGE. 35 yrs. 3 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Accountant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Kuhkel Service Co.

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.
10-NAME OF FATHER, Daniel H. Doyle
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland
12-MAIDEN NAME OF MOTHER, Catherine A. Flynn
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) William H. Doyle
(Address) 1619 Bolton St.

15-
Filed ..... 192.....

APR 21 1924 ROBERT R. KRANTZ, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 18. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 10 1924 to April 18 1924 that I last saw h. alive on April 18 1924 and that death occurred, on the date stated above, at 11.45 P. M.

The CAUSE OF DEATH* was as follows:

Primary Carcinosis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleural effusion

(Duration) about 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes - Removed during last year Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. O'Donovan, M. D

April 19, 1924 (Address) 5 E. Read St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	4/21 19.24

20-UNDERTAKER,	ADDRESS
Henry W. Mears & Son	805 N. Calvert

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86093

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mordicai Levine.

(a) RESIDENCE NO. 117 N. Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. 2 ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Levine

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Frank Levine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Findinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Frank Levine (Address) 117 N Broadway

15 Filed APR 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 18th, 1924, to April 20, 1924, that I last saw him alive on Apr 20, 1924, and that death occurred, on the date stated above, at 11.25 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) 0 yrs. 0 mos 18 hrs

CONTRIBUTORY (Secondary) Chronic Broncho-pneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Stoller Jos Shemer, M. D.

(Address) Hebrew Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL April 21 1924

20 UNDERTAKER S. Levinson Bro — ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

INK—THIS IS A PERMANENT RECORD. Every item of infor-

Cor.—1-12-23—M&T—100 Bks.

86094 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 86094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 W. Lee St. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cornelius Hinton. (C)

(a) RESIDENCE NO 643 W. Lee St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 1st. 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hinton. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina.

12 MAIDEN NAME OF MOTHER Clara Proctor. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina.

14 Informant Clara Hinton. (C) mother
(Address) 643 W. Lee St.

15 Filed APR 21 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronco-pneumonia.
primary.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs.

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

April 20. 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemty.

DATE OF BURIAL April 21 1924

20 UNDERTAKER R. L. Parham

ADDRESS 902 Lombard St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- ay be properly classified. terms, so that it may be

Spec.—1-10-21—M&T—1500 Bks.

Long.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86095

CERTIFICATE OF DEATH.

38 D 86095

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 334-N-Bruce ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Long

(a) RESIDENCE NO. 334-N-Bruce ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas Long

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Loretta Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard Co Md

14 Informant Thomas Long
(Address) 334 N-Bruce St.

15 Filed APR 21 1924 Robert P. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1924

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 20, 1924, that I last saw h- alive on April 20, 1924, and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Freeman, M. D.

, 19 (Address) 618-W-Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 21st 1924
20 UNDERTAKER	ADDRESS
A. Jones	111 S. Gilmor st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of infor-

Cor.—1-12-23—M&T—100 Bks.

D 86096

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 86096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 Indiana Ave. Westport ST., 25 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond T. Rudy.

(a) RESIDENCE No 640 Indiana Ave. Westport ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January, 30, 1924.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

800

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward T Rudy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond, Va.

12 MAIDEN NAME OF MOTHER Alphay G. Cumber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond, Va.

14 Informant Edward J. Rudy. (father)
(Address) 640 Indiana Ave. Westport.

15 APR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
primary
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Oedema.
(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)
April 20, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL 4/21 1924

20 UNDERTAKER John J. Fields

ADDRESS 1200 W. Lombard

IMPORTANT.—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86097

CERTIFICATE OF DEATH.

90 ✓ D 86097.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1711 Lemmon St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Frank W. Bricar

(Residence in Baltimore: No. 1711 Lemmon St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

6-DATE OF BIRTH. July (Month) 5 (Day) 1851 (Year)

7-AGE. 73 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Cement Wks

9-BIRTHPLACE, (State or Country). St Marys Co

PARENTS:

10-NAME OF FATHER. Bricar

11-BIRTHPLACE OF FATHER, (State or Country). St Marys Co

12-MAIDEN NAME OF MOTHER. Linton

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Bricar

(Address) 1711 Lemmon St

15. APR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 19 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) James M. Hanlon M. D. (Coroner)

April 19 1924 (Address) 2 W Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
New Cathedral	April 22 1924
20-UNDERTAKER.	ADDRESS
Wm Stubbs	120 W Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86098

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 Parrish St ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Smith

(a) RESIDENCE. No. 1018 Parrish St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith -

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Smith (Daughter)

(Address) 1018 Parrish St

APR 21 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to April 18, 1924,

that I last saw h.e alive on April 18, 1924,

and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

~~Cardiac Asthma~~

Valvular Heart Disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) J. Thos. Fulton, M. D.

, 19 (Address) 1001 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Cemetery	4-21 1924
20 UNDERTAKER	ADDRESS
Dent Carter	914 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51

D 86099

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Brown

(a) Residence No. 509 Ogston St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1900

7-AGE.	If LESS than 1 day,
24 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 013

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). N. Carolina

PARENTS.

10-NAME OF FATHER. Whilley Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER. Ida Ross

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N. Carolina

11- (Informant) Municipal Hospital Records

(Address)

APR 21 1924 192.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-17-24

17- I HEREBY CERTIFY, That I attended deceased from 4-15 1924 to 4-17 1924

that I last saw h[illegible] alive on 4-17 1924

and that death occurred, on the date stated above, at 3'15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

Rheumatic Endocarditis and Pericarditis

Myocardial Failure

(Duration) yrs. mos. 1 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Heaver M. D.

4-19 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Vaughan Md	4-21 1924
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Park Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-21—M&T—100 Blks.

D 86100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 86100

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mersity Hospital ST., 14 WARD)

2-FULL NAME Jim Kane

(a) RESIDENCE NO 607 Wilson St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 36 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wood Tinsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) East Tenn

12 MAIDEN NAME OF MOTHER Sally Timms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) East Tenn

14 Informant Mrs C White
(Address) 777 W. Mulberry St

15 Date APR 21 1924 Informant ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18-1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body

(duration) ... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Clothing accidentally caught fire

(duration) ... yrs. ... mos. ... ds.

(Signed) H H Bruner, M. D.
(Coroner.)

4-20, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-21-24 1924
20 UNDERTAKER David Easton	ADDRESS 916 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86101

CERTIFICATE OF DEATH.

15 12 D 86101

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2219 Roslyn Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Jesse Hamilton Graham

(a) Residence No. 2219 Roslyn Avenue St., 15 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 51 yrs. 6 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nannie B. Graham

6-DATE OF BIRTH (month, day and year) Sept-25-1872

7-AGE.	If LESS than 1 day.
51 yrs. 6 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)... Furnaces

(c) Name of employer..... Quaker Mfg. Co.

9-BIRTHPLACE (city or town) (State or Country)... Washington D.C.

PARENTS.

10-NAME OF FATHER, Robert Graham

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Washington D.C.

12-MAIDEN NAME OF MOTHER, Anne Padgett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D.C.

14- (Informant) Mrs. Nannie B. Graham (wife)
(Address) 2219 Roslyn Avenue.

15- Filed APR 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 17-'24

17- I HEREBY CERTIFY, That I attended deceased from Apr. 13- , 1924., to Apr. 17- , 1924, that I last saw him alive on Apr. 17- , 1924., and that death occurred, on the date stated above, at 8-15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) - yrs. - mos. 1 ds.

CONTRIBUTORY (Secondary) Acute hepatic congestion

(Duration) - yrs. - mos. 6 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Mount Cemetery	Apr 21, 1924
20-UNDERTAKER. GEBHART & MOWEN COMPANY WILLIAM E. WOODEN, Successor	ADDRESS 108 W. NORTH AVE.

T(DA AN LY AT HE NE TH

ced EXACTLY. PHYSICIANS sl fied. Exact statement of OCCUF should be carefully supplied. AGE should be stated E In plain terms, so that it may be properly classified. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-092 D 86102

Registered No.....

1-PLACE OF DEATH (Bay View Hospital 8

City of BALTIMORE: (No.....St., ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Susie Merrick

(a) Residence No. 2177 E. Chase St., ...Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George W. Merrick

6-DATE OF BIRTH (month, day and year) 1850

7-AGE. 70 yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None 637

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Dorchester Co Md.

PARENTS.

10-NAME OF FATHER. Benjamin F Moffit

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Sarah Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England Wales

14- (Informant) Geo A. Merrick

(Address) 2127 E. Chase st

15- APR 21 1924 ROBERT H. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 19 1924

17- I HEREBY CERTIFY, That I attended deceased from March 5 1924 to April 19 1924

that I last saw h.. alive on April 18 1924

and that death occurred, on the date stated above, at 3.20 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (terminal)

.....(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) H. F. Corbett M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Bay View	Apl 22 24
20-UNDERTAKER. Clark Johnson	ADDRESS 1 W. Pray

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86103

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-003

D 86103

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hosp ST., 15 WARD)

2-FULL NAME Sophia Frank

(a) RESIDENCE NO. 1831 Clifton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Frank

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS, than 1 day, ... hrs. or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis
(Address) 1439 Eutaw St

15 APR 21 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

THE CAUSE OF DEATH was as follows: Auto Accident

Multiple Fractures

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo Claude Rhodes M. D.
(Coroner.)

4/20/24 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery Baltimore Md DATE OF BURIAL 4/21 192 4

20 UNDERTAKER Jack Levis ADDRESS 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86104 D 86104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1103 N. Broadway St., 8 Ward)

Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Liba M. Dribinsky

(a) Residence No. 1103 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pacus Dribinsky

6-DATE OF BIRTH (month, day and year)

7-AGE. 60 yrs. — mos. — ds.

If LESS than 1 day. hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). 07

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Harry Taken

(Address) 1103 N. Broadway

15- Filed 192 ROBERT R. KRAUTER, Registrar.

APR 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/20/24

17- I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to Apr. 20, 1924

that I last saw h.. alive on April 19, 1924

and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urea retention Phthalein Tuberculin test

(Signed) Wm F. Taylor M. D.

4/21, 1924 (Address) 1254 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hebrew Rosedale — DATE OF BURIAL, 3/21, 192X

20-UNDERTAKER. Jack Levin — ADDRESS 1439 E Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86105

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH CITY OF BALTIMORE, (No. 105 Asquith St. Hebrew Aged Home ST., 5 WARD)

2-FULL NAME Sherman Harris

(a) RESIDENCE No. 105 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Biddle

15 Filed APR 21 1924 ROBERT P. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17

I HEREBY CERTIFY, That I attended deceased from April 16, 19 24, to April 20, 19 24,

that I last saw him alive on April 20, 19 24,

and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Chron. Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Bamberger, M. D.

4/20, 19 24 (Address) 210 Asquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendmen Ass'n, DATE OF BURIAL April 24 1924

20 UNDERTAKER Jacob Lewis, ADDRESS 1439 E. Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86106

Harvey.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 86106

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1230 Bayard ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME george Harvy

(a) RESIDENCE. NO. 1230 Bayard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colrd

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) — 1814

7 AGE 40 Years — Months — Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Maggie Harvy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: maggie Harvy (Address) 1230 Bayard St

15 Filed ..... 19.. Registrar

APR 21 1924 ROBERT P. KRAUSE Public Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to April 18, 1924, that I last saw him alive on April 18, 1924, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary): Cardiac asthma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Bailey Hoey, M. D.

April 21 1924 (Address) 729 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auburn cemetery — DATE OF BURIAL: April 21 1924

20 UNDERTAKER: John H Toadvine — ADDRESS: 1027 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86107

CERTIFICATE OF DEATH.

185 D 86107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Chandler

(a) RESIDENCE NO. 1433 Penna. Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hay Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Joseph Chandler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Bailey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Elizabeth Chandler
(Address) 1433 Penna ave.

15 Filed APR 21 1924 ROBERT M. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1924

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1924, to April 17, 1924, that I last saw him alive on April 16, 1924, and that death occurred, on the date stated above, at 1:45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Terminal Pneumonia
Osteomyelitis femur (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Endo- and myo-cardytis
fract. left femur - Arteriosclerosis & hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1433 Penna Ave.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B Sybert, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apr 21 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 142 W Fayette St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 86108

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1151 W. Hamburg ST., 21 WARD)

2-FULL NAME Lena Ross.

(a) RESIDENCE NO. 1151 W. Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Ross

6 DATE OF BIRTH (month, day, and year) Dec 29, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	3	21.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry W. Niemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary. Mehlhoff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant George W. Ross.
(Address) 1151 W. Hamburg St.

15 Filed APR 21 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Apr 19, 1924.

that I last saw h.. alive on Apr 19 1924

and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) John G. Brunsdens M. D.

, 19 (Address) 11 Newlewon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL Apr. 22 1924

20 UNDERTAKER Mr - Mrs. John W. Kempfel & Son — ADDRESS 801 W. Fayette

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state be properly classified. Exact statement of OCCUPA- of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86109

CERTIFICATE OF DEATH.

161-001 D 86109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Druid Hill Ave ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nilson

(a) RESIDENCE NO. 1406 Druid Hill Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Nelson

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D. C.

12 MAIDEN NAME OF MOTHER Annie Savage

13 BIRTHPLACE OF MOTHER (city or town) Ft Monroe
(State or country) Virginia.

14 Informant Mother
(Address)

15 ROBERT R. KRAUTH,
Registrar

APR 21 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to April 17, 1924,

that I last saw h/malive on April 17, 1924,

and that death occurred, on the date stated above, at 1.45 PM m.

The CAUSE OF DEATH* was as follows:

Prematurity -
Foetus burned in furnace at University Hospital (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alfonso Lee, M. D.

4/19, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Foetus Burned)

DATE OF BURIAL 19

UNDERTAKER

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Body at city morgue (Vansant)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86110

CERTIFICATE OF DEATH.

3/✓ D 86110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 659 Rubey ST., 4 WARD)

2-FULL NAME Mrs Vansant

(a) RESIDENCE NO 659 Rubey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Don't Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 70				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant W R Gorsuch
(Address) 112 N. Eutaw

15 APR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Don't Know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W R Gorsuch, M. D.
(Coroner.)

4-18, 1924 (Address) 112 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon

DATE OF BURIAL 4/20/1924

20 UNDERTAKER W G Gross ADDRESS 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 86111

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-09 B 86111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Hillen St ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Henry Taylor

(a) RESIDENCE NO. 923 Hillen St Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) July 1 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Bessie Landon

13 BIRTHPLACE OF MOTHER (city or town) Towson
(State or country) Baltimore Md

14 Informant Bessie Taylor
(Address) 923 Hillen St Balto Md

15 APR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to April 19, 1924.

that I last saw him alive on April 18, 1924.

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 4 yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) General weakness

(duration) 4 yrs. 4 mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of lungs

(Signed) S. D. F. Burgan M. D.

(Address) 5202 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest. Fm

DATE OF BURIAL April 1924

20 UNDERTAKER Mark C. Elliott

ADDRESS 1245 Eastlands

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

86112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 86112

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1416 Marshall St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella J. Burrier.

(a) Residence No. 1416 Marshall St., 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female.

4-COLOR OR RACE: White.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles E. Burrier

6-DATE OF BIRTH (month, day and year): March, 2, 1868

7-AGE: 56 yrs. 1 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At, home. 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Frederick Co. Md.

PARENTS.

10-NAME OF FATHER: John Moore.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England.

12-MAIDEN NAME OF MOTHER: Sarah Lepley.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Fredick Co. Md.

14-

(Informant): Mary A. Roberts. (Sister)

(Address): Elkridge Howard Co. Md.

15-

FILED APR 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 19-1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to April 19, 1924

that I last saw h.. alive on April 18, 1924

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcenoma of Liver

about 1 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. P. Eckenrack, M. D.

Apl 19, 1924 (Address) 1412 Light St.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park Cemetery

DATE OF BURIAL, April, 23, 1924.

20-UNDERTAKER: J. Howard Evans

ADDRESS: 38 E. Fort Ave.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Blks.

D 86113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86113

CERTIFICATE OF DEATH.

205-002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 Penns ave St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Anderson

(a) RESIDENCE NO. 1915 Penns ave St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh.	Child -

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
#		11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1915 Penns Ave

PARENTS

10 NAME OF FATHER Emanuel Anderson

11 BIRTHPLACE OF FATHER (city or town) Charlotte ville (State or country) Va

12 MAIDEN NAME OF MOTHER Minnie Bell

13 BIRTHPLACE OF MOTHER (city or town) Charlotte ville (State or country) Va

14 Informant Minnie Anderson
(Address) 1915 Penns Ave

15 APR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18 1924

17 I HEREBY CERTIFY, That I attended deceased from (Jan.) 4-18 - 1924 to (7-45 A.M.) 4-18 1924

that I last saw him alive on (4-18-) (7.45 A.M.) 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Dentition

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. H. Walters, M. D.

(Address) 1311 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fort Auburn Cmty	4-21 1924
20 UNDERTAKER George T. A. Gibson	ADDRESS 1737 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86114

CERTIFICATE OF DEATH.

11-002

D 86114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Retreat ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Genegee

(a) RESIDENCE NO. 531 Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20-1871

7 AGE 52 Years 10 Months 28 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic D10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Menefee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Amanda Poke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Florence Menefee 531 Roland Ave

15 Filed APR 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 31, 1924, to Apr. 18, 1924, that I last saw her alive on Apr. 18, 1924, and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Ac. Glomerulo Nephritis

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Symptomatic

(Signed) W. T. Carr M. D.

, 19 (Address) 515 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Int Auburn Cem — DATE OF BURIAL 4-22 1924

20 UNDERTAKER George T. A. Gibson — ADDRESS 1734 Druid Hill Ave

INSTRUCTIONS

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86115

X 51

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 238½ N. Bond St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lula Jones

(a) Residence No. 238½ N. Bond St., Ward. Mill (Colored)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 40 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework 070

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Ella Bevan

(Address) 238½ N. Bond St.

APR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 16, 1924 to Apr 18, 1924

that I last saw h[illegible] alive on Apr 18, 1924

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

Rheumatic Fever

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) W. Clyde Burns, M. D.

Apr 17, 1924 (Address) 1017 E. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Druid cemetery	April 22, 1924.
20-UNDERTAKER,	ADDRESS
Edward Bryan	631 Orleans St

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86116

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 86116

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 S. Kenwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Gorecki

(a) RESIDENCE. No. 923 S. Kenwood Ave ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? 44 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stanislaus Gorecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Francis Kowalewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

11 Informant Stanislaus Gorecki

(Address) 923 S Kenwood Ave

15 Filed ..... 19.....

APR 21 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 19, 1924, that I last saw him alive on April 19, 1924, and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & Sputum.

(Signed) John V. Szczubicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	April 21- 1924
20 UNDERTAKER	ADDRESS
Stephen J Fialkowski	100 S Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86117

REGISTERED NO. 59-002 ✓ 1 5 9 D 86117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Fleet ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARGARET BIELAT,

(a) RESIDENCE NO. 1933 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. I9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	8	I9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, pw

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.

PARENTS

10 NAME OF FATHER Thomas Bielat,

11 BIRTHPLACE OF FATHER (city or town) Baltimore, (State or country) MD.

12 MAIDEN NAME OF MOTHER Elizabeth Lambden,

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, (State or country) MD.

14 Informant Elizabeth Bielat, (Mother) (~~WIFE~~)

(Address) 1933 Fleet Street

15 APR 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April I9. 1924.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 19, 1924.

that I last saw h[illegible] alive on April 18, 1924

and that death occurred, on the date stated above, at 3.30 A- m.

The CAUSE OF DEATH* was as follows:

(a) Bronchopneumonia Left Front Lobe

(duration) yrs. 0 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? /

What test confirmed diagnosis?

(Signed) C. Wilson Kyser M. D.

(Address) 801 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL 4/21. 1924

20 UNDERTAKER M. F. Sadowski. ADDRESS 705 S. Ann

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86118

CERTIFICATE OF DEATH.

168 D 86118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Carlton ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Martin

(a) RESIDENCE NO 1419 Madison ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie C. ...

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	5-3 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Trim
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer Yapi Bros. 023

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm. T. Martin

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country)

14 Informant Police Dept.
(Address)

15 Filed APR 21 1924 ROBERT. R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wounds by hanging

Sudden (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

... (duration) ... yrs. ... mos. ... ds.

(Signed) W. F. Kelly, M. D.

Apr. 20, 1924 (Address) (Coroner) 39 Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/21/1924

20 UNDERTAKER E. J. Fanning & Son — ADDRESS 1938 E. Lafayette Ave

CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 86119

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

D 86119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital for the Women of Maryland

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette & John ST.) 17 WARD)

2-FULL NAME Mrs. Mary May Hill

(a) RESIDENCE NO. 671 W. Franklin St. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~entire~~ yrs. ~~entire~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ ~~(or)~~ WIFE of Mr. Harry R. Hill

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lewisburg, Pa.

PARENTS

10 NAME OF FATHER LaRue Johnson

11 BIRTHPLACE OF FATHER (city or town) Lewisburg (State or country) Pa.

12 MAIDEN NAME OF MOTHER Lucinda Bridges

13 BIRTHPLACE OF MOTHER (city or town) Lewisburg (State or country) Pa.

14 Informant Mr. Harry R. Hill (husband)

(Address) 671 W. Franklin St.

15 Filed APR 21 1924, 19 ROBERT R. KRAUTER, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to April 20, 1924,

that I last saw her alive on April 20, 1924,

and that death occurred, on the date stated above, at 8:55 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hyperthyroidism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of April 19, 1924

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam.

(Signed) J. Ogle Warfield Jr. M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	4/23/24
20 UNDERTAKER	ADDRESS
G A Kemper Son	Hanover Pa

(OVER)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

D 86120

1-PLACE OF DEATH [redacted] Battery Ave St., 24 Ward) Registered No.....

City of BALTIMORE: (No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma D Jones

(a) Residence No. 1224 Battery Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Jones

6-DATE OF BIRTH (month, day and year): Mar 10 1848

7-AGE: 76 yrs. 1 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: do

9-BIRTHPLACE (city or town) (State or Country): Balto.

PARENTS.

10-NAME OF FATHER: Levin V. Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto.

12-MAIDEN NAME OF MOTHER: Unknown.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto.

14- (Informant) Mrs. Ruth Baker
(Address) 1224 Battery Ave.

15- Filed APR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr 17 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1923 19.... to Apr 17 24 19....
that I last saw her alive on Apr 17 24 19....
and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(Duration) 1 yrs. X mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm B Kolb M. D.

Apr 18 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem — DATE OF BURIAL: 4/23 1924

20-UNDERTAKER: W C Kumao Son — ADDRESS: 703 Hanover St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓

D 36121

D 36121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 W Franklin ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry F. Hall

(a) RESIDENCE NO. 808 W Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— 000

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Hall

11 BIRTHPLACE OF FATHER (city or town) Rockingat
(State or country) N C

12 MAIDEN NAME OF MOTHER Mary Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town) Charleston
(State or country) W Va

14 Informant Charles Hall
(Address) 808 W Franklin

APR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1924 to April 18, 1924.
that I last saw him alive on April 18, 1924,
and that death occurred, on the date stated above, at 11.55 a m.

The CAUSE OF DEATH* was as follows:

1 Lobar Pneumonia

(duration) — yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ———

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Howell M. D.

4/21, 1924 (Address) 1911 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt R Cubura Cem.

DATE OF BURIAL 4/21 1924

20 UNDERTAKER Samuel J Wellesley

ADDRESS 28 Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 ✓

167 D 86122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 W Lanvale ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Dickerson

(a) RESIDENCE No. 524 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Dickerson

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O'Neill
(c) Name of employer

9 BIRTHPLACE (city or town) Ned Georgetown
(State or country)

PARENTS

10 NAME OF FATHER John H. Dickerson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mulberry

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Estate Lambert
(Address) New York City

15 Date APR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:*

Suicide
Ill. Gas

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

(Signed) Geo Clinton Bates M. D.
(Coroner.)
4/21/24 192 (Address) 1143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: Apr. 21 1924

20 UNDERTAKER: Saml. Nemsley ADDRESS: W. Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86123

CERTIFICATE OF DEATH.

8 9 D 86123

1-PLACE OF DEATH

City of BALTIMORE. (No. 1309 N. Broadway St. 8 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Alex Clark

(a) Residence No. 1309 N. Broadway St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah L. P. Clark

6-DATE OF BIRTH (month, day and year) May 1-1848

7-AGE. 75 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Dep.

(b) General nature of Industry, business, or establishment in which employed (or employer). Warden

(c) Name of employer. Md. Pen. 1906

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. James Alex Clark

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Elizabeth A. Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Hannah L. P. Clark

(Address) 1309 N. Broadway

15- APR 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19-1924

17- I HEREBY CERTIFY, That I attended deceased from April 16 1924 to Apr 19 1924 that I last saw h. alive on April 19 1924 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis &
Pleuritic effusion

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Abdominal Hypertension

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Personal Observation &c

(Signed) Geo F Taylor M. D

, 19 (Address) 1207 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem

DATE OF BURIAL. 4/23- 19 24

UNDERTAKER, Chas. F. Fraser & Son

ADDRESS 1101 N. Mt. Royal Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 86124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D 86124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 656 Portland ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles G. Landbeck

(a) RESIDENCE. NO. 656 Portland ST., 22 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64 yrs.	2 "		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush maker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto., Md
(State or country)

PARENTS

10 NAME OF FATHER Christian G. Landbeck

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Andress

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs E. Eckhardt
(Address) 656 Portland St.

15 Filed APR 21 1924 16 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1924, to April 19, 1924, that I last saw him alive on April 18, 1924, and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

about

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilitation of heart

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Harry Boyd, M. D.

, 19 (Address) 602 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/22 1924
20 UNDERTAKER Geo Leimbach & Son	ADDRESS 647 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86125

HEALTH DEPARTMENT--CITY OF BALTIMORE

99-002 ✓

CERTIFICATE OF DEATH

D 86125

1 PLACE OF DEATH

REGISTERED NO. C .....

CITY OF BALTIMORE (No. 1116 Carrollton Ave 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Edward E Kerr

(Residence in Baltimore: No. 1116 Carrollton Ave St. ~~Mo~~ yrs 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: August 22 (Month) (Day), 1862 (Year)

7 AGE: 41 yrs. 7 mos. 28 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer): 004

9 BIRTHPLACE (State or country): Md

PARENTS

10 NAME OF FATHER: Chas H. Kerr

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary J. Lloyd

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. H. Kerr

(Address) 1116 Carrollton

15 DATE RECEIVED: APR 21 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 19 (Month) (Day), 1924 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to April 19, 1924 that I saw h[illegible] alive on April 19, 1924 and that death occurred, on the date stated above, at 1100 m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 4 yrs. mos. ds

Contributory (SECONDARY) Cirrhosis

(Duration) yrs. mos. ds.

(Signed) L. L. Hausman M. D.

4-21, 1924 (Address) L. L. Hausman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Cuba

19 PLACE OF BURIAL OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 4/22/1924

20 UNDERTAKER: Geo. T. A. Gibson

ADDRESS: 735 David St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 86126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 101 D 86126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital St. ..... WARD)

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H Brown

(a) RESIDENCE No. Lutherville Md St. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Susie L. Brown

6 DATE OF BIRTH (month, day, and year) Feb. 22-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	1	28.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Susie L. Brown
(Address) Lutherville Md.

15 Filed ..... 192.. ROBERT R. KRAUTER, Burial Permit Clerk ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Its death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 2 ds.

(Signed) Fred Elliott Blades, M. D.
(Coroner)

4/21/24, 192 (Address) 145 E. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... ntos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bayview Potters Field Baltimore County Grounds — DATE OF BURIAL 4/23/1924

20 UNDERTAKER George J. A. Gibson — ADDRESS 1335 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state ..... supplied. AGE ..... of infor-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86127

CERTIFICATE OF DEATH.

1559-002 ✓ D 86127

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 W Mulberry ST., 20 WARD)

2-FULL NAME Mildred M Helwig

(a) RESIDENCE NO. 3901 W Mulberry ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ~~X~~ yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 4-19-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Helwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary B. Helwig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Helwig (Address) 39-41 W Mulberry St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

APR 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-1924

17 I HEREBY CERTIFY, That I attended deceased from 4-19- ..... 1924 ..... to 4-20 1924,

that I last saw her alive on 4-20 1924,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

General debility

(Cause unknown)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos B Hall ..... M. D.

..... 19 (Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Babylon	4/22 19 24
20 UNDERTAKER W. S. Sills	ADDRESS 2120 Edmondson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86128

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001 ✓

D 86128

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St. + Rutland Ave 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dichter.

(a) RESIDENCE NO. 221 No. Carlton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Dichter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jack Lewis (Address) 1439 E Baltimore

15 FILED APR 21 1924 ROBERT A. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/24 19

17

I HEREBY CERTIFY, That I attended deceased from 4/19, 1924, to 4/21, 1924,

that I last saw him alive on 4/21, 1924,

and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure,

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Strangulated inguinal hernia. (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/19/24

Hemiplasty - right and left.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isidore L. Fry M. D.

Apr. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew Cem	4/22 1924
20 UNDERTAKER Jack Lewis	ADDRESS 1439 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D 86129

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86129

CERTIFICATE OF DEATH.

REGISTERED NO. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3604 E. Pratt St. St.; 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madelena D'Amario

(Residence in Baltimore: No. 3604 E. Pratt St. St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Jan. (Month) 22 (Day), 1880 (Year)

7-AGE, 44 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Angelo Latini

11-BIRTHPLACE OF FATHER (State or Country), Italy.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Italy.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nicola D'Amario

(Address) 3604 E. Pratt St.

15- Filed APR 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 19 (Day), 1924 (Year).

17- I HEREBY CERTIFY, That I attended deceased from 1-17- 1924, to 4-19-1924, that I saw h[illegible] alive on 4-18- 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvular
[illegible]
Cardiac Dilatation
(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pul. Tub. Hemorrhage
Debility (Duration) yrs. mos. 6 ds.

(Signed) J. J. Duncan M. D.

4-21-, 1924 (Address) 1604 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem.	April 23, 1924
20-UNDERTAKER Lilly & Son	ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86130 ✓

D 86130

CERTIFICATE OF DEATH.

122-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 N. Patterson Park Ave. ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Soter

(a) RESIDENCE NO. 1705 N. Patterson Park Ave ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lorenz Soter

6 DATE OF BIRTH (month, day, and year) Mar. 24 - 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Adam Bihn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Kempf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Josephine Schaech

(Address) 1705 N. Patterson Park Ave

15 Filed APR 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1924, to April 18, 1924, that I last saw her alive on April 18, 1924, and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Hepatic Cirrhosis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Symptoms

(Signed) Geo Edwin Brady M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL April 22 1924

20 UNDERTAKER Lilly & Son

ADDRESS 403 S. Wolfe St.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86131

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86131

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1178 S. First ST., 26 WARD)

2-FULL NAME Frank A. Stessler.

(a) RESIDENCE NO. 1178 S. First St. ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Stessler.

6 DATE OF BIRTH (month, day, and year) Nov. 13-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Joseph Schwintuch.

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Adam Stessler.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Christina Stessler.
(Address) 1178 S. First St.

15 Filed APR 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1924, to April 19, 1924,
that I last saw him alive on April 18, 1924
and that death occurred, on the date stated above, at 4.30 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Sigmoid.

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of about 2 mos ago

Was there an autopsy? No

What test confirmed diagnosis? Microscope -

(Signed) Caleb A Bothey M. D.

April 20, 1924 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart. Cem.

DATE OF BURIAL April 22 1924

20 UNDERTAKER Lilly and Zulu

ADDRESS 403 S. Howard St.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86132

CERTIFICATE OF DEATH.

179 D 86132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Hurd

(a) RESIDENCE NO. 1316 First ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Hurd.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Penn.

12 MAIDEN NAME OF MOTHER Edie Farrell

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant George Hurd.
(Address) 1316 E. First St.

15 Filed ..... 192 .....
ROBERT M. KRAUTER,
Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident
Scald 1st Second Degree
(duration) yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Toxemia
(duration) yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Blake M. D.
4/20/24, 192 (Address) 1436 Bway

*State (a) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem,	April 21 192 4
20 UNDERTAKER Lilly and Zeller	ADDRESS 403 S. Mo[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D 86133

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓

D 86133

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Mount Hope Retreat ST., 2-8th WARD)

2-FULL NAME Frederick J Hehring-

(a) RESIDENCE No. Mount Hope Retreat ST., 2 8th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married-

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Hehring-

6 DATE OF BIRTH (month, day, and year) Sept 21-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer —

034

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Hehring-

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md-

12 MAIDEN NAME OF MOTHER Louise Krause

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Rector of Mt Hope Retreat (Address) Baltimore Md.

15 Filed APR 21 1926 19 ROBERT N. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1926

17

I HEREBY CERTIFY, That I attended deceased from July 20th, 1917, to Apr 19, 1926,

that I last saw h alive on Apr. 19, 1926,

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia - Post Gen- Neuritis

abt (duration) 7 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Chr Man. Psychosis-

abt (duration) 7 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL April 23 1926

20 UNDERTAKER Lilly & Fuhr

ADDRESS 403 N Howard

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Sidaravicus

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86134

CERTIFICATE OF DEATH.

31 D 86134

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 813 N Bueltoad ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mattew Sedaravich Sedaravich

(a) RESIDENCE NO. 813 N Bueltoad ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
— —

6 DATE OF BIRTH (month, day, and year) No 1869

7 AGE 55 Years	— Months	+ Days	— If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work NO
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer — —

9 BIRTHPLACE (city or town) .....
(State or country) Lithvania

PARENTS

10 NAME OF FATHER Maetew Sedaravich

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER Mary Yurca

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Lithvania

14
Informant Mrs M. Sedaravich
(Address) 418 S Paca St.

15
Filed APR 21 1924 192.. ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Pul. T. B.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Columbus Blade, M. D.
(Coroner)

4-20-24 192.. (Address) 473 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOLY REDEEMER	April 22, 1924
20 UNDERTAKER	ADDRESS
John Grebliauckas J.G.	425 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86135

CERTIFICATE OF DEATH.

D 86135

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1527 Penn Ave ST. WARD 14)

REGISTERED No. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Nottage

(a) RESIDENCE NO. 1527 Penn ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Boland Nottage

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bahama Island

12 MAIDEN NAME OF MOTHER Catherine Bolden

13 BIRTHPLACE OF MOTHER (city or town) Do
(State or country)

14 Informant Boland Nottage
(Address) 1524 Penn Ave

15 Filed APR 21 1924 Robert F. Harrison,
Burial Permit Clerk.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH was as follows:

Gastritis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) G Scott Black, M. D.
4/21/24 (Coroner) (Address) 143 E Bway

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ht Hebron	Apr 24 1924
20 UNDERTAKER	ADDRESS
Chas H. Chase Sons	1100 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86136

CERTIFICATE OF DEATH.

90 D 86136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 W. Saratoga ST., 18 WARD)

2-FULL NAME John B. Rowlins

(a) RESIDENCE NO. 1120 W. Saratoga ST., 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	55	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Calvert County Md.

PARENTS

10 NAME OF FATHER James Rowlins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Mary Freeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Priscilla Hooper (Mary)
(Address) Edmondson Ave.

15 Filed APR 21 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1924, to Apr. 20, 1924, that I last saw him alive on April 19, 1924, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Reese, M. D.

, 19 (Address) 1219 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Elm	Apr 22 1924
20 UNDERTAKER	ADDRESS
Jane F. Chase Undertaker	1400 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86137

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 544 E. 22nd. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ann Collett

(a) Residence No. 544 E. 22nd. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Collett

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. 82 yrs. -- mos. -- ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Thomas Gaffney

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Healy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11- (Informant) James P. Gaffney

(Address) 544 E. 22nd. St.

15- Filed 4 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 20-24

17- I HEREBY CERTIFY, That I attended deceased from ..... Year 1 ..... 1909 ..... to ..... April 20 ..... 1924 .....

that I last saw h.. alive on ..... April 19 ..... 1924 .....

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Valvular)

unknown (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) ....yrs. 1 mos. ....ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill M. D

, 19 (Address) Wyliesburg Reisterstown Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	4/22 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. CAUSE OF DEATH should be carefully supplied. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Use instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86138

CERTIFICATE OF DEATH.

101-001 ✓

D 86138

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Chelsea & Cedar Roads St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Mae Rohrbach

(a) Residence No. Chelsea & Cedar Roads St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry A. Rohrbach

6-DATE OF BIRTH (month, day and year) Feby-1-1896

7-AGE, 28 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Thomas B. Finkler Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Harpers Ferry W. Va

12-MAIDEN NAME OF MOTHER, Ida May Phillips

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Ida May Finkler

(Address) Chelsea & Cedar Roads

15- APR 21 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 26, 19 24 to Apr. 20, 19 24

that I last saw her alive on Apr-19, 19 24

and that death occurred, on the date stated above, at 7.25 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar left lower with Lobar secondary infection and extension to upper and right side (Doration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Premature Labor at 7 M. (Duration) yrs. mos. 26 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Ex.

(Signed) Wesley Call M. D.

4/21, 19 (Address) 702 Fremont.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cemetery	April 23 19 24
20-UNDERTAKER.	ADDRESS
Harry R. Almacock	4204 Ridgewood Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86139

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 ✓ D 86139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Davis

(a) RESIDENCE No. 1417 Anthony ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3- 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Kate Bosley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Robert E. Harrison, Registrar

Burial Permit Clerk.

APR 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1924, to April 19, 1924

that I last saw him alive on April 19, 1924,

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis - congenital

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan, M. D.

4/19, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	APR 21 19
20 UNDERTAKER	ADDRESS
Commissioner Health.	

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86140

CERTIFICATE OF DEATH.

D 86140

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1819 St Paul St., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Katherine McDonnell Conroy.

(a) RESIDENCE. No. 1819 St Paul St ST., 13 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Conroy

6 DATE OF BIRTH (month, day, and year) Jan 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Clerical)

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER P. H. McDonnell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ann Conroy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs McDonnell
(Address) 1525 N Wolfe St

15 Filed APR 21 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 19

17 I HEREBY CERTIFY, That I attended deceased from March 15 19 to April 19 19

that I last saw h alive on April 19 19

and that death occurred, on the date stated above, at 4.50 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cardiac Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Percy C Hunt, M. D.

, 19 (Address) 19 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 24 1924

20 UNDERTAKER Henry H Jenkins Sons Co

ADDRESS Orchard & McCulloh Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86141 D 86141

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Tucker

(a) RESIDENCE No. 1215 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry A. Tucker

6 DATE OF BIRTH (month, day, and year): Aug 13 1849

7 AGE: Years 74 Months 8 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: James R. Forman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Decir Colby

(Address): Balto Co Md

15 Filed Robert P. Harrison, Registrar

R 2 1 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-21-1924

17

I HEREBY CERTIFY, That I attended deceased from 1-16-, 1924, to 4-21-, 1924,

that I last saw h alive on 4-21-, 1924,

and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with metastasis spine & liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. Barr, M. D.

(Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem Co Md	Apr 23 1924
20 UNDERTAKER	ADDRESS
Wm L Underwood Sons	North Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86142

CERTIFICATE OF DEATH.

31 ✓

D 86142

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 303 W. Maple Ave Overlea St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Philip Greiser

(a) Residence No. 303 W. Maple Ave Overlea St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 9. 1873

7-AGE. 50 yrs. 10 mos. 10 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Watchman

(b) General nature of industry, business, or establishment in which employed (or employer). 062

(c) Name of employer. Ramsey Bldg

9-BIRTHPLACE (city or town) Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER. Peter Greiser

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Anna C. Koppelman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-* (Informant). George Greiser

(Address). 303 W. Maple ave Overlea

15- APR 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 16th 1924 to April 19th 1924

that I last saw him alive on April 19th 1924

and that death occurred, on the date stated above, at 5.35 P. m.

The CAUSE OF DEATH* was as follows:

1. Tuberculosis of Pre Sternum
(with pressure on right bronchus)
2. Extreme Exhaustion

1 year 6 mos.
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. F. Lockwood M. D

, 19 (Address) 8 E. Eager St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	April 22 1924
20-UNDERTAKER.	ADDRESS
H. Sander Sons	1710 Fleet St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86143

CERTIFICATE OF DEATH.

101-001 D 86143

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Rutland ave. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Graham

(a) RESIDENCE NO. 1219 Rutland Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Graham

6 DATE OF BIRTH (month, day, and year): Feby 14, 1872

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: — Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Chas H. Graham

(Address) 1219 Rutland ave

15 Filed APR 22 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to April 21, 1924.

that I last saw h.er alive on April 20, 1924

and that death occurred, on the date stated above, at 7:50 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Apl

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. W. Kramer, M. D.

, 19 (Address) 1813 W. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Apr 23 1924

20 UNDERTAKER: John A. Mitchell — ADDRESS: 201 N. Fayette

D 86144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86144

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Mulberry St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Nichols

(Residence in Baltimore: No. 1412 Mulberry St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH.

..... 1.....
(Month) (Day) (Year)

7-AGE.

58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Ds

9-BIRTHPLACE, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgiana Nichols

(Address) 1412 Mulberry St

15- APR 22 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis 2

(Duration) yrs. mos. ds.

(Signed) H. Ernest Blake M. D.
(Coroner.)

19?? (Address) 143 N. Paca

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Laurel Cemetery	Apr. 22 1924

20-UNDERTAKER,	ADDRESS
Chas. H. Wilson	467 N. Caroline St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 86145

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 244 S Chester St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Constance Rybarczyk

(a) Residence No..... 244 S Chester St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 5 1924

7-AGE, — yrs. — mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Rybarczyk

11-BIRTHPLACE OF FATHER (city or town)..... Baltimore
(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Julia Sawicki

13-BIRTHPLACE OF MOTHER (city or town)..... Poland
(State or Country),

14- (Informant)..... Joseph Rybarczyk Father
(Address)..... 244 S Chester Street

15- Filed APR 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 20/24

17- I HEREBY CERTIFY, That I attended deceased from April 17, 1924 to April 20, 1924 that I last saw h[illegible] alive on April 20, 1924 and that death occurred, on the date stated above, at 1030 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

4/21, 1924 (Address) 1937 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Rosary — DATE OF BURIAL, April 22 1924

20-UNDERTAKER. John A. Webb — ADDRESS 1803 Bank St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-28-21—E.B.R.S.—400 Bks.

(Loukota)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86146

CERTIFICATE OF DEATH.

104-002

D 86146

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 914 N. Bradford St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Marie Loukota

(a) Residence No. 914 N. Bradford St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frank Loukota

6-DATE OF BIRTH (month, day and year) Not known

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto

PARENTS

10-NAME OF FATHER, Thos Handlick

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Maria Landa

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Bohemia

14- (Informant) Frank Loukota
(Address) 914 N. Bradford St

15- Filed APR 22 1924 192... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19 1924

17- I HEREBY CERTIFY, That I attended deceased from March 1 1924 to April 19 1924 that I last saw h[illegible] alive on April 18 1924 and that death occurred, on the date stated above, at 1150 A. M. The CAUSE OF DEATH* was as follows:

Primary — Pyonephrosis
Contributory — Endocarditis
Contributory — Diffuse Peritonitis
Duration — 1 yr. mos. ds.

CONTRIBUTORY (Secondary) acute Edema of Lungs
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.
4-20 19 (Address) 806 N. Bradford St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL. April 22 1924

20-UNDERTAKER, Frank E. Crockett — ADDRESS 1906 Eastlake Ave

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

– 32 D 86147

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 318 East St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Domenico Tamminello

(a) Residence No. 318 East St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Sept 20/23

7-AGE: .....yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant 6d
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS:
10-NAME OF FATHER, Thos. Tamminello
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy
12-MAIDEN NAME OF MOTHER, Helen Johnson
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-
(Informant) Thos Tamminello
(Address) 318 East St

15-
Filed APR 22 1924 19.....
ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 21/24

17- I HEREBY CERTIFY, That I attended deceased from April 16 19..., to April 21 19 24, that I last saw h.. alive on April 21 19 24, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculus Meningitis

(Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Janiszeski M. D
4/24 19 (Address) 2431 Fait Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 23 19 24

20-UNDERTAKER: Frank Enoch & Son — ADDRESS: 1406 Ashland Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D 86148

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 N. Washington ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kocourek

(a) RESIDENCE. No. 925 N. Washington ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? 12 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Marie Kocourek

6 DATE OF BIRTH (month, day, and year) June 20—1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer For himself 045

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Fred—Kocourek (Son)
(Address) 7th Madison Ave

15 Filed APR 22 1924, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan—15, 1924, to April 20, 1924, that I last saw him alive on April 20th, 1924 and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

about (duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Loss of appetite general Weakness (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? yes —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Samuel A Davis, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 24 1924
20 UNDERTAKER	ADDRESS
Trout & Crack Son	1906 Eutaw

INSTRUCTIONS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86149

CERTIFICATE OF DEATH.

144 D 86149

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1655 N Milton ave St. 8 WARD)

2-FULL NAME Anna E Fischer

(a) RESIDENCE NO. 1655 N Milton ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Fischer

6 DATE OF BIRTH (month, day, and year) Sep 6 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Michael Pfister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant John Fischer
(Address) 1655 N Milton ave

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1924, to April 20, 1924,

that I last saw her alive on April 20, 1924,

and that death occurred, on the date stated above, at 9.50 Pm.

The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage + Collapse

(duration) yrs. mos 6 hrs

CONTRIBUTORY (Secondary) Confinement

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. B. Cannon, M. D.

4 21 1924 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 22 1924

20 UNDERTAKER Wendell Dyffel & Son — ADDRESS 37 S Amm

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86150

CERTIFICATE OF DEATH.

101-001

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Johns Hopkins Hospital ST. 5 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out also No. 18.)

2 FULL NAME Emma H. Waters

(Residence in Baltimore: No. 917 Hillen St

Life

St.; yrs., mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	Colored	Single

6-DATE OF BIRTH, Nov 27, 1894
(Month) (Day) (Year)

7-AGE, 29 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Walter Waters

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Wilks

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edna Roberson

(Address) 1738 N Wallas St

15- ROBERT A. KRAUTER, Burial Permit Clerk.

Filed..... 191... Registrar.

APR 22 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I held an Autopsy of the remains described above, held at .....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) H Rawlings

(Duration) yrs. mos. 2 ds.

(Signed) H. S. Clinton Taylor M. D.
(Coroner.)

4/20/24 191... (Address) 143 W Eager

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Apr 22, 1924

20-UNDERTAKER F W Seitz

ADDRESS 709 W 33rd St

Cor.—1-12-23—M&T—100 Bks.

D 86151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86151

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Grist

(a) RESIDENCE NO. Belmont House ST., Calvert Stream WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Street sweeper
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Rev. A. B. Kunsdorf
(Address)

15 APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

and 9 days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Riley, M. D.

(Coroner.)

April, 1924 (Address) 1259 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State about 1 1/2 Yrs. yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr. 22 1924
20 UNDERTAKER	ADDRESS
John Outterbridge	1218 W. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 86152 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86152

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST., 5 WARD)

2-FULL NAME Abrahams Brill

(a) RESIDENCE No. 115 aisquith st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	m	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Brill

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of Industry, business, or establishment in which employed (or employer) formerly 088

(c) Name of employer Shoemaker

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Leurs

(Address) 1439 E Balto st

15 Filed APR 22 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 19 24

17 I HEREBY CERTIFY, That I attended deceased from April 20, 19 24, to April 21, 19 24,

that I last saw him alive on April 21, 19 24,

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) M D Baughman, M. D.

4/21, 19 24 (Address) 210 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 4/22 1924

20 UNDERTAKER Jack Leurs

ADDRESS 1439 E Balto st

APR 22 1924

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86153

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 111-005 86153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Kadin

(a) RESIDENCE NO. Parkersburg W. Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 15 ds. How long in U. S., if of foreign birth? 15 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mollie Kadin Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watch
(b) General nature of industry, business, or establishment in which employed (or employer) Maker 439
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Russia

PARENTS

10 NAME OF FATHER Joe Kadin

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Shondzettin

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 5 1924 to April 20 1924,
that I last saw him alive on April 20 1924,
and that death occurred, on the date stated above, at 3 P- m.
The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

(duration) 10 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of April 7-24
Was there an autopsy? No
What test confirmed diagnosis? Clinical Operation
(Signed) James Hubert Wilkerson M. D.
..... 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chicago Ill — DATE OF BURIAL 4-22 1924

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 86154

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2823 Huntingdon Ave) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Edward C Fox

(a) Residence No. 2823 Huntingdon Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mamie E Fox

6-DATE OF BIRTH (month, day and year) Oct 6 1873

7-AGE. 50 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Veterinarian

(b) General nature of industry, business, or establishment in which employed (or employer) 05

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Edward C Fox

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Johanna Yeager

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-INFORMANT, Mamie E Fox

(Address) 2823 Huntingdon

15-FILED APR 22 1924 BY ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 19 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 192 4, to April 19, 192 4, that I last saw him alive on April 19, 192 4, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Emphysema

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lumacyn - BP

(Signed) [illegible] M. D.

4/21, 1924 (Address) 11 Allegheny St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn

DATE OF BURIAL, Apl 22 1924

20-UNDERTAKER CHENOWETH & SON,

ADDRESS 3617 CHESTNUT AVE.

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Nettie Irwin

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86155

CERTIFICATE OF DEATH.

197 D 86155

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

2-FULL NAME Nettie Irwin

(a) RESIDENCE No 638 Burgundy alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of — Irwin

6 DATE OF BIRTH (month, day, and year) — 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — at Home
(b) General nature of industry, business, or establishment in which employed (or employer) — 03
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) — Balto. Md

PARENTS

10 NAME OF FATHER — Samuel Ruggard

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Md

12 MAIDEN NAME OF MOTHER — Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Md

14 Informant — Sarah Ruggard
(Address) 920 Wanda St

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) — 4-17- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquiry~~) thereon and from the evidence obtained by said ..... (Inquest, autopsy ~~or inquiry~~) find that said deceased came to ther death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stomatic Peritonetis. Shot by Oliver Brown

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Gunshot wound

(duration) yrs. mos. 3 ds.

(Signed) W. H. Jones, M. D.
(Coroner)

4-22, 1924 (Address) 1717 Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt. Auburn — DATE OF BURIAL 4-22 1924

20 UNDERTAKER — John H. Toadvine — ADDRESS 442 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 86156

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 86156

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 S Stricker ST.: 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Roeder

(a) RESIDENCE. No. 817 S. Stricker ST., 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Bernard Roeder

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kowalewska

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

11 Informant Bernard Roeder
(Address) 817 S. ROBERT P. KRAMER,

15 APR 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1924, to April 21, 1924, that I last saw him alive on April 21, 1924, and that death occurred, on the date stated above, at 1145 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Caleb N Athey, M. D.

April 22, 1924 (Address) 1008 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	April 25 1924
20 UNDERTAKER	ADDRESS
Stephen L Fralkowski	1125 S Ellwood Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86157

CERTIFICATE OF DEATH.

162

D 86157

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N Bruce ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Nickens

(a) RESIDENCE NO. 1805 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18. 1924

7 AGE Years Months Days If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene Nickens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Richmond Co. Virginia

12 MAIDEN NAME OF MOTHER Annie Lang

13 BIRTHPLACE OF MOTHER (city or town) Greenville
(State or country) North Carolina

14 Informant Mother
(Address)

15 Filed APR 22 1924 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18 1924 to April 18 1924

that I last saw him alive on April 18 1924

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur Reese M. D.

4/21 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL: April 24 1924

20 UNDERTAKER by doctor, Commissioner of Health.

ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

125

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86158

1-PLACE OF DEATH

City of BALTIMORE: (No. 3708 E Pratt St., 76 Ward) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Knochel

(a) Residence No. 3708 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mes. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Johanna Knochel

6-DATE OF BIRTH (month, day and year): Mar 6. 1851

7-AGE: 72 yrs. 4 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany.

PARENTS.

10-NAME OF FATHER: Christopher Knochel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant): H. Stanley Knochel

(Address): 3708 E. Pratt St

15-Filed APR 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 20/1924

17-I HEREBY CERTIFY, That I attended deceased from April 11 1924 to April 20 1924

that I last saw him alive on April 20 1924

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Dr. Stapleton M. D.

4/21, 1924 (Address) 330 E Baltimore St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. DATE OF BURIAL: Ap 23, 1924

20-UNDERTAKER: John Ulrich ADDRESS: 228 Adams

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86159

CERTIFICATE OF DEATH.

161-001 D 86159

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2307 Foster Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Wierzyn

(a) Residence No. 2307 Foster Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 18 1924

7-AGE. ....yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Hd

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, Michael Wierzyn

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Teresa Zielenska

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or Country),

11- (Informant) Michael Wierzyn

(Address) 2307 Foster Ave

15- Filed APR 22 1924 192. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 21, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1924 to ..... 19.....

that I last saw him alive on Apr. 21, 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Gnomulsion

(Duration) ....yrs. ....mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? P S & S

(Signed) John J. Krager M. D.

, 19 (Address) 8627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus	Apr 22 19.24
20-UNDERTAKER.	**ADDRESS**
M. F. Sadowski	795 S. Ann St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86160

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 737 S. Linwood Ave. 1 ST., WARD)

2-FULL NAME Jos J. Mroczka

(a) RESIDENCE NO 737 S. Linwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Mroczka,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work First class ships cook
(b) General nature of industry, business, or establishment in which employed (or employer) on the U.S.A.
(c) Name of employer Navy ship Cumberland,

9 BIRTHPLACE (city or town) Buffalo,
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Jacob Mroczka,

11 BIRTHPLACE OF FATHER (city or town) Poland,
(State or country)

12 MAIDEN NAME OF MOTHER Julia Daniel,

13 BIRTHPLACE OF MOTHER (city or town) Poland,
(State or country)

14 Informant Josephine Mroczka
(Address) # 737 So. Linwood Ave

15 Filed APR 22 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:*

Myocarditis

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronch Comp. 1 (duration) yrs. mos. ds.

(Signed) Geo Lenhart Stader, M. D.
(Coroner)

4/21/24 192 (Address) 145 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ST. STANISLAUS CEM.,	April 24 1924.
UNDERTAKER M F. Sadowski,	ADDRESS 705 S. Ann St

DEATH is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. If LESS than 1 day, hours or minutes must be given. PHYSICIANS should state plain terms, so that it may be

Spec.—1-10-21—M&T—1500 Blks.

D 86161

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D 86161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1347 Cookrill ST., 24 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Unnamed Infant Stogen

(a) RESIDENCE NO. 1347 Cookrill ST., 24 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4.21.24

7 AGE	Years	Months	Days	If LESS than 1 day, [illegible] or 1 min.
		9m	Fortal	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thos Stogen

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Mary Richnigg

13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)

14 Informant Thos Stogen
(Address) 1347 Cookrill St

15 Filed APR 22 1924, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.21.1924

17 I HEREBY CERTIFY, That I attended deceased from 4.21, 1924, to 4.21, 1924, that I last saw him alive on 4.21, 1924, and that death occurred, on the date stated above, at 9.40 P m.

The CAUSE OF DEATH* was as follows:

Dystocia

(duration) During Birth yrs. mos. ds.

CONTRIBUTORY (Secondary) Dystocia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L Darlington, M. D.

, 19 (Address) 102 E Fort ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem | DATE OF BURIAL Apr. 23 1924

20 UNDERTAKER John Butterfield | ADDRESS 120 W. Fayette St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

36162

36162

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 839 N. Luzerne ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella M Amend

(a) RESIDENCE No. 839 N. Luzerne ST., WARD 7

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~—~~ 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John Amend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Francis Amend
(Address) 839 N Luzerne

15 APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21/24 19

17 I HEREBY CERTIFY, That I attended deceased from 3/20/24, 19, to 4/21, 19 24.

that I last saw h alive on 4/20/24, 19.

and that death occurred, on the date stated above, at 4 10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 1

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) W H Engle, M. D.

4/21, 1924 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	4/24 1924
20 UNDERTAKER	ADDRESS
G F Pipitone	1006 E 32nd

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 1 D 86163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 541 N Luzerne ST., 7 WARD)

2-FULL NAME George Od'Donnell Stappler

(a) RESIDENCE NO. 541 N Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 30 1918

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
6	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm St Stappler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Nadie ADonnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary Od'Donnell
(Address) 541 N Luzerne

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1924, to April 20, 1924, that I last saw h living alive on April 20, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Dr Louis Rose, M. D.

(Address) 1101 E Baltimore St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 4/23/24

20 UNDERTAKER: Frank V. Pikestone — ADDRESS: 1800 E 31st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

Hollenberry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86164

CERTIFICATE OF DEATH.

4 x 188-003 D 86164

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis E. Hollenberry.

(a) RESIDENCE NO Rose Hill Rhesvich ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Boy, 6yr
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER C. E. Hollenberry

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Brooks

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant C. E. Hollenberry
(Address) Rhesville Md

15 [illegible] APR 22 1924 ROBERT R. KRAUTER Clerk, Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy~~ or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, ~~or~~ ~~inquiry.~~) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

(duration) ... yrs. 2 Hours mos. ... ds.

CONTRIBUTORY (Secondary) Struck by Automobile

(duration) ... yrs. ... mos. ... ds.

(Signed) H. H. Young, M. D.
(Coroner.)

4-22, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel Bcm — DATE OF BURIAL April 22 1924

20 UNDERTAKER W M Routson — ADDRESS 2238 N Mott

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Arbough)

D 86165 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001

CERTIFICATE OF DEATH. D 86165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 96 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amos N. Arbaugh

(a) RESIDENCE No. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Jane Arbaugh

6 DATE OF BIRTH (month, day, and year) Aug 4th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Conrad Albaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records
(Address)

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-11, 1923, to 4-21, 1924 that I last saw him alive on 4-20, 1924 and that death occurred, on the date stated above, at 3.00 p. m.

The CAUSE OF DEATH* was as follows:

Senile Debilitation

Senile Dementia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sept.

(Signed) Claude G. Drane M. D.

4-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carrollton, Carroll Co. Md.	Apr 23 1924
20 UNDERTAKER	ADDRESS
J. W. Cook	5022 Guilford Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86166

CERTIFICATE OF DEATH.

41 D 86166

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital (St.) (Ward)

2-FULL NAME Edward Freeman

(a) RESIDENCE NO. 1520 Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Orie Freeman

6 DATE OF BIRTH (month, day, and year) Aug 12th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 078

(b) General nature of industry, business, or establishment in which employed (or employer) Wiloman

(c) Name of employer W. R. R.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Sarah Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mayfield Reed

(Address)

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/31/24 19..., to 4/26/24 19...,

that I last saw h... alive on 4/24/24 19...,

and that death occurred, on the date stated above, at 11.10 m.

The CAUSE OF DEATH* was as follows:

Acute Epicardyocarditis

(duration) ... yrs. 1 mos 20th ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) N. W. Kelly M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apr 24 1924
20 UNDERTAKER W. H. Cook	ADDRESS 502 E North Ave.

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86167

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 86167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No Broadway and Fairmount ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Cruden.

(a) RESIDENCE NO. 1008 E. North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lithographer 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Peabody Post.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Pedro Cruden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Hill

(Address) 1318 Eutaw Pl. Balto

APR 22 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1924

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1924. to April 22, 1924.

that I last saw him alive on April 22, 1924.

and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene, left foot

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical.

(Signed) Captain Cameron M. D.

, 19 (Address) Church Home City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Apr 24, 1924

20 UNDERTAKER ADDRESS

Wm. Tesh & Son E. Monument

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

86168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86168

CERTIFICATE OF DEATH.

24 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 109 E. Randall St. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Hood

(a) Residence No. 109 E. Randall St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bradley J. Hood

6-DATE OF BIRTH (month, day and year) June 20 1849

7-AGE. 74 yrs. 10 mos. 0 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, James Relay

11-BIRTHPLACE OF FATHER (city or town)..... Md.
(State or Country).

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Unknown
(State or Country).

14-
(Informant)..... Mr. White
(Address)..... 109 E. Randall St.

15-
APR 22 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 27 1924 to April 20 1924

that I last saw h. alive on April 19 1924

and that death occurred, on the date stated above, at 10 Am.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite (Duration) yrs mos ds

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed) R. R. Campbell M. D.

April 21 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: April 23 1924

20-UNDERTAKER: J. Frew McCully — ADDRESS: 130 E. Fort Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86169

CERTIFICATE OF DEATH.

1924 D 86169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Druid Hill Park (ST.) 21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert F. Floyd

(a) RESIDENCE NO. 211 Sarah (ST.) 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 9 mos. 15 ds. How long in U. S., If of foreign birth? —— yrs. —— mos. —— ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ——
(b) General nature of industry, business, or establishment in which employed (or employer) ——
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Woodyard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert County Md

14 Informant
(Address) 211 Sarah St

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning
Accidental

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Chas. A. Morrison M. D.
(Coroner.)

April 21, 1924 (Address) 3672 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: April 24 1924

20 UNDERTAKER: H. S. Waltemeyer — ADDRESS: 2356 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86170

129

D 86170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 853 w. Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Minnie Forwood

(a) Residence No. 853 w. Fayette St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Forwood

6-DATE OF BIRTH (month, day and year) Sept 27 1889

7-AGE. 34 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... None

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Warren Gelbert

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Louise Osterlock

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14- (Informant) William J. Forwood

(Address) 853 W. Fayette St.

15- Filed APR 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20 1924

17- I HEREBY CERTIFY, That I attended deceased from August 1 1923 to April 20 1924, that I last saw h.. alive on April 20 1924, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Carbuncle

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Stafford Brand M. D.

, 19 (Address) 622 Mosher

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	Apr 23 1924
20-UNDERTAKER,	**ADDRESS**
Fos Goodens & Son	2173 Pen.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17083 Md

D 86171 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 129 D 86171

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8 WARD)

2-FULL NAME Lillian Steedman

(a) RESIDENCE NO. 2417 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. [illegible] mos. ? ds. ? How long in U. S., if of foreign birth? 18 yrs. 1 mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Apr 18, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	18	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar worker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Steedman Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 JOHNS HOPKINS HOSPITAL Informant (Address)

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1924, to April 20, 1924,

that I last saw her alive on April 20 1924,

and that death occurred, on the date stated above, at 9 55 A m.

The CAUSE OF DEATH* was as follows:

Malignant hypertension

Chronic nephritis 4 (duration) yrs. mos da.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 40 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phthalein. Blood Urea.

(Signed) James McKeen, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Apr 23 1924

20 UNDERTAKER Jos Joerdens Son

ADDRESS 2178 Boone

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86172

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 407 N. Stricker St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. David Leftridge Rohr

(a) Residence No. 407 N. Stricker St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lucy J. Rohr

6-DATE OF BIRTH (month, day and year) Dec 20 1853

7-AGE. 72 yrs. 4 mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 050

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Painter

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Staunton Va

PARENTS.

10-NAME OF FATHER, Frederick Rohr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Dont Know

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dont Know

14- (Informant) Mrs. Mildred Forrest

(Address) 407 N. Stricker St.

15- FILED APR 22 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20 1924

17- I HEREBY CERTIFY, That I attended deceased from 2/10/23 19.. to 4/20/ 1924

that I last saw h.. alive on 4/20/24 19..

and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Hypertension.

.....(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

.....(Duration) 12 hr. yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) C. Emmett Rohr M. D

4/21, 1924 (Address) 910 W. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Olivet Cem. DATE OF BURIAL, April 22 1924

20-UNDERTAKER, Jas Joerdens Son ADDRESS 2073 S. Pace

SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86173

CERTIFICATE OF DEATH.

3 D 86173

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE (No. 1605 N. Pat. Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie A Hesse.

(a) Residence No. 1605 N Paterson Pk Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Geo. Hesse.

6-DATE OF BIRTH (month, day and year) Feb 14, 1898

7-AGE, 26 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 631
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Herman F Garmatz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Mary E Goring

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14-
(Informant)
(Address) 2112 N Paterson Pk Ave

15-
APR 22 1924
Registrar.
ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 20, 1924.

17- I HEREBY CERTIFY, That I attended deceased from Mch 22, 1924, to Apr 20, 1924, that I last saw her alive on Apr 20, 1924, and that death occurred, on the date stated above, at 7 40 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
Arthritis (Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Tubercle bacilli Etc

(Signed) W. I. Watson, M. D.

Apr 22, 1924 (Address) 2128 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore	April 23. 1924
20-UNDERTAKER, L. Keenan.	ADDRESS 32 N. Broadway

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 N. Edew ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Henderson

(a) RESIDENCE NO. 727 N. Edew ST., WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	Widow

5a If married, widowed, or divorced (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Appox 92	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or estabiishment in which employed (or employer) 0-0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Elliott (undertaker)

(Address) 1725 E Ashland Ave

15 APR 22 1924 ROBERT R. KRAUTER (Registrar) Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to April 20, 1924,

that I last saw h[illegible] alive on April 20, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic. Convulsions and unilateral paralysis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) R A Elliott, M. D.

4/20 1924 (Address) 1725 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Henderson Station N.C.

DATE OF BURIAL April 22 1924

20 UNDERTAKER Wm R A Elliott

ADDRESS 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Davage

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90 D 86175

CERTIFICATE OF DEATH.

D 86175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 560 Pulaski ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rhoda Davage

(a) RESIDENCE NO. 560 Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Color	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Davage

6 DATE OF BIRTH (month, day, and year) Oct 15-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) private

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER William Jolley

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Summers

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Bessie Downes
(Address) 560 Pulaski

15 Filed APR 22 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19th, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1924, to April 19th, 1924,

that I last saw h alive on April 18th 1924

and that death occurred, on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

(Address) 922 Mon.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md.	4/22/1924
20 UNDERTAKER Samuel B Hawley	ADDRESS 1128 N Caddall

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 86176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 86176

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 S. Parrish ST., 19 WARD)

2-FULL NAME Amelia Brandt

(a) RESIDENCE NO. 302 S. Parrish ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ehlen Brandt.

6 DATE OF BIRTH (month, day, and year) Dec 10, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Helins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Menzing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ehlen Brandt
(Address) 302 S Parrish

15 Filed ..... 19 .....

APR 22 1924 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1923, to apl 19, 1924, that I last saw her alive on Apl 18, 1924, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder Ureter

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Digital

(Signed) P. Grier Carr Dill M. D.

4/21 1924 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apl 22 1924
20 UNDERTAKER	ADDRESS
Harry H Witzke	453 W Lombard St

INFORMATION should be carefully supplied. AGE at CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRINT WITH PURPLE PRINTING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86177

CERTIFICATE OF DEATH.

+ 129 ✓

D 86177

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Frank Rivers

(a) RESIDENCE NO. Laurel Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred x yrs. x mos. 3 x ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	x Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of x

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
18 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) x (State or country) New York

PARENTS

10 NAME OF FATHER x Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) x Unknown

12 MAIDEN NAME OF MOTHER x Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) x Unknown

14 Informant University Hospital (Address)

15 APR 22 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1924

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 22, 1924.

that I last saw h[illegible] alive on April 22, 1924.

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate - Cystitis

Chronic nephritis & cardiac decompensation

Chronic (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of x

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests.

(Signed) E. Thomas M. D.

, 19 (Address) Laurel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gr Hill Laurel Md.	Apr 24 1924
20 UNDERTAKER	ADDRESS
Geo E French	Laurel Md.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86178 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86178

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. Monument St., 13 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius H. Fisher.

(a) RESIDENCE NO. 2214 Bryant Apt St., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. 1 mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fisher

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
26	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing
(b) General nature of Industry, business, or establishment in which employed (or employer) Mfg 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Harris Fisher
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Esther Lehrman
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 Essex St

Filed APR 22 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1924.

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 22, 1924, that I last saw h.. alive on 3:10 A.M., 1924, and that death occurred, on the date stated above, at 3:15 A.m.

The CAUSE OF DEATH* was as follows:
Pneumococcus Septicemia
Type IV

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological

(Signed) Isadore L. Fry, M. D.
(Apr. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	4-27 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 Eastern Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D 86179

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Moran

(a) Residence No. 1601 W Fayette St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Dec 23 1862

7-AGE. 61 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic 070

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14- (Informant) Charles Moran

(Address) 1601 W Fayette St

15- APR 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21 24

17. I HEREBY CERTIFY, That I attended deceased from Feb 6. 19 24 to April 21 19 24

that I last saw h.. alive on April 21 19 24

and that death occurred, on the date stated above, at 4 PM

The CAUSE OF DEATH* was as follows:

Pneumonia due to
Lung Metastases

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Breast Carcinoma

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Phys. Findings

(Signed) H O Harper M. D

, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mas Cathedral	April 22, 1924
20-UNDERTAKER,	ADDRESS
John J Fields	1200 N Fountain

EXACTLY. PHYSICIANS should state CAUSE OF DEATH
Exact statement of OCCUPATION is very important. See
in plain terms, so that it may be properly classified. Exa
instructions on back of certificates.
Should be carefully supplied. AGE should be stated

D 86180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86180

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3136 Strickland St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William Thiele

(Residence in Baltimore: No. 3136 Strickland St.; yrs. 89 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, Oct (Month) 13 (Day) 1833 (Year)

7-AGE, 90 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Butcher

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Catherine Fuchs

(Address) 3136 Strickland St.

15- Robert P. Garrison, 192.....

Registrar.

Burial Permit Clerk.

R 27924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 20 (Month) (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(Duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. ds.

(Signed) James M. Hinton M. D.
(Coroner.)

April 21 192 4 (Address) 709 E. Chased

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	April 23. 1924
20-UNDERTAKER. C. W. Dill	ADDRESS 2109 Fredk. Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86181

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 86181

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3203 Dillon ST.: N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Webb

(a) RESIDENCE. NO. 3203 Dillon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Webb.

6 DATE OF BIRTH (month, day, and year) June 15, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (H.W.)

(b) General nature of industry, business, or establishment in which employed (or employer) None (H.W.)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Geser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Webb (Address) 3203 Dillon St

15 Filed APR 22 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20- 1924

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1924, to April 20, 1924, that I last saw her alive on April 20, 1924, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency, following diabetic gangrene of the right foot

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 1 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D. B. Bromwhar M. D.

4-21- 1924 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	April 28 1924
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Fleet

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86182

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 001 ✓ D 86182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 210 S Gough St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E. Baust

(a) Residence No. 210 S Gough St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Baust

6-DATE OF BIRTH (month, day and year) Jan 14, 1856

7-AGE, 68 yrs. 3 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 269

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles Hennick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary E Hilbert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Wm Sible

(Address) 210 S Gough St

15- Robert P. Harrison, Registrar.

APR 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 14 19 22 to Apr 20 19 24

that I last saw h.. alive on Apr. 16 19 24,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/24, 1924 (Signed) E H Mengert, M. D (Address) 1634 E Biddle.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	April 23, 1924
20-UNDERTAKER. H. Sander Sons	ADDRESS 1710 Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86183

CERTIFICATE OF DEATH.

9 57

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1609 E. 30th St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Wenzel

(a) Residence No. 1609 E. 30th St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katherine Wenzel

6-DATE OF BIRTH (month, day and year) Nov. 10, 1859

7-AGE. 64 yrs. 5 mos. 11 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired 2 years

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Not Known

14- (Informant) Katherine Wenzel

(Address) 1609 E. 30th St

15- APR 22 1924 Robert F. Karl Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to April 21 1924

that I last saw him alive on April 14 1924

and that death occurred, on the date stated above, at 1P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D

4/22 1924 (Address) 1228 Harford Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine Cem.	April 24 1924
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Park Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 86184

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward) 47

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Brown

(a) Residence No. 3012 Matthews St., Ward

(Usual place of abode) unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If ~~married~~, widowed, or divorced HUSBAND of (or) WIFE of Edw J Brown

6-DATE OF BIRTH (month, day and year) ? ? 1881

7-AGE. 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Jack Webb

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Rose Webb

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14-

(Informant) Municipal Hospital Records

(Address)

15-

Filed ..... 19.. Robert F. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-22-24

17- I HEREBY CERTIFY, That I attended deceased from 4-3 19.24 to 4-22 19.24

that I last saw h.. alive on 4-21 19.24

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 1924

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude B. Drane M. D.

4-22-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Quantico Va, DATE OF BURIAL, Apr 24 1924

20-UNDERTAKER, Wm Leech & Son ADDRESS 502 E Main

APR 22 1924 Burial Permit Clerk.

an

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 90 D 36185

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 Aisquith St., 5 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Mary J. Smith

(a) Residence No... 207 Aisquith St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1829

7-AGE,	If LESS than 1 day,
95 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Talbot Co Md

PARENTS.

10-NAME OF FATHER, Henry Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Talbot Co, Md

12-MAIDEN NAME OF MOTHER, Annis Flamer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Talbot Co Md

14- (Informant) Annis C. Gould

(Address) 1527 Argyle Ave.

15- Filed APR 22 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 14, 1924 to Apr 20 1924

that I last saw h alive on April 19 1924

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

Indefinite (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

Apr 20 1924 (Address) 1612 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	April 23, 1924.
20-UNDERTAKER.	**ADDRESS**
Mrs. Katie R. Williams	322 N. Schroeder St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86186 (Lewis) CERTIFICATE OF DEATH. 49 D 86186

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5401 Jonquil Ave ST. 27 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Lewis

(Residence in Baltimore: No. 5401 Jonquil Ave St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August (Month) 17 (Day), 1873 (Year)

7-AGE, 50 yrs. ..... mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John W. Lewis

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Lavinia L. Taylor

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore County Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ora B. Klutch

(Address) 3220 Auchentoroly Terrace

15-

Filed ..... Robert P. Harrison, Registrar.

APR 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 22 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 11, 1924, to April 22 1924, that I saw him alive on April 20 1924, and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Carcinoma

(Duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma Testis

(Duration) 2 yrs. — mos. — ds.

(Signed) C. B. Kluch M. D.

4-22, 1924. (Address) 5016 Park Av. Tel. One

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Great Neck L.I. 1924

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park

DATE OF BURIAL, April 24, 1924

20-UNDERTAKER George J. Smith

ADDRESS 532 Hollins st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... very important. See instructions on back of certificate. ... AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. ... of information should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86187

CERTIFICATE OF DEATH.

129 D 86187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ennis Millholland

(a) RESIDENCE NO. 71 N. Curley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Ellen MacKey

6 DATE OF BIRTH (month, day, and year) Aug-30-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co

PARENTS

10 NAME OF FATHER Robert Millholland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland. unk.

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant Daughter Mrs Margaret Millholland

(Address) 12 Cornelius Road Relto Md.

15 FILED R 22 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1923, to Apr 20, 1924,

that I last saw h~~e~~ alive on April 20, 1924,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart, aortic and mitral

(duration) Longstanding yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis, chronic interstitial nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) W. S. Forbes, M. D.

19 (Address) U.S. Marine Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	Apr 23rd, 24
20 UNDERTAKER J. G. Moan	ADDRESS 3 ab E Balto

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86188

CERTIFICATE OF DEATH.

74001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1012 S. Sharp St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albertina Kotmair

(a) Residence No. 1012 S. Sharp St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Casper Kotmair

6-DATE OF BIRTH (month, day and year): Dec. 31. 1865

7-AGE: 58 yrs. 3 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Joseph Hiersh

11-BIRTHPLACE OF FATHER (city or town) (State or Country): germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant): Louis Kotmair (Son)

(Address): 1012 S. Sharp St.

15- Registrar.

PR 22 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 20. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 19, 1924, that I last saw h.. alive on April 19, 1924, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an antopsy? No

What test confirmed diagnosis?

(Signed) A. Becker Jr. M. D.

Apl. 21, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Most Holy Redeemer	April 24, 1924
20-UNDERTAKER,	**ADDRESS**
Margaret G. Flynn	1422 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-00 D 86189

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No. Md General Hospital ST., 13 WARD)

2-FULL NAME Mrs. C. Hulett

(a) RESIDENCE No. 3308 Black Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	4	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rail Road
(b) General nature of industry, business, or establishment in which employed (or employer) Brakeman
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harvie Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Burk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W L Hunt
(Address) 3315 Barclay

15 2 2 1924, 192 Robert P. Harris, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

*Accident
Fracture of Pelvis
Shock (duration) yrs. mos. 6 hrs.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 6 ds.

(Signed) G Ellwood Wales, M. D.
(Coroner.)
4/23/24, 192 (Address) 746 E Broad

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apr 24 24
20 UNDERTAKER E LeRoy Stiffler	ADDRESS 1331 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Schoff)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 86190

D 86190

CERTIFICATE OF DEATH.

6 117

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 219 N. Bouldin St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John G. Schoff

(a) Residence No. 219 N. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R. Schoff

6-DATE OF BIRTH (month, day and year) June 9 1874

7-AGE. 50 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer Phillips Bros.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John G. Schoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Elizabeth Stanley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Anna R. Schoff

(Address) 219 N. Bouldin St.

15- Filed..... Robert P. Harrison, Registrar.

R 22 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 15 1924 to Apr 24 1924

that I last saw h alive on Apr 24 1924

and that death occurred, on the date stated above, at 8 15 m.

The CAUSE OF DEATH* was as follows:

Cancer Esophagus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Gastritis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Mergedant M. D.

4/26 1924 (Address) 1638 E. Baltimore St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. April 25 1924

20-UNDERTAKER. Wm. Lambert & Son ADDRESS E. Baltimore

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Blades, Bray & Fayette Sts

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86191

CERTIFICATE OF DEATH.

1 85 D 86191

1-PLACE OF DEATH Municipal Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Jane E Walker

(a) RESIDENCE No. 1735 Townsend Place ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Walker

6 DATE OF BIRTH (month, day, and year) Dec 14, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Penna

PARENTS

10 NAME OF FATHER John Wyble

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Deland

12 MAIDEN NAME OF MOTHER Charlotte Auburn

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Penna

14 Informant Alice A Walker (Address) 1735 Townsend Place

15 Filed ..... 192 Robert P. Harrison, Registrar

APR 22 1924 Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Fracture of Hip
3 (duration) yrs. 7 mos. ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. 2 mos. ds.

(Signed) Jno Ellis Jones M. D.
4/23/24 (Coroner.)
192 (Address) 1437 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., 7 ds. In the State 76 yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....
1735 Townsend Place
Former or usual residence 1735 Townsend Place

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Apr 23 192 4
20 UNDERTAKER J. M. Cook	ADDRESS 302 E Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of AGE should be stated EXACTLY. PHYSICIANS and state TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 86192

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Branch

(a) RESIDENCE NO. 320 Diamond Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred √ yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) unknown 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Martha Curtis
(Address) 429 Druid Hill Ave

15 Filed APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Autopsy at Hopkins Hospital)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Cain, M. D.
(Coroner.)

Apr 18/24 92 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Apr 23, 24

20 UNDERTAKER Samuel D. Stansbury — ADDRESS 1125 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86193

CERTIFICATE OF DEATH.

144 D 86193

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 424 Mosher ST., 14 WARD)

2-FULL NAME Ella L. Blackwell

(a) RESIDENCE NO. 424 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31 1892

7 AGE — Years: 32 — Months: 3 — Days: 22 — If LESS than 1 day..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Frazier School

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Royston Blackwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Louisa Pott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Louisa Blackwell
(Address) 424 Mosher St

15 Filed APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Laryngitis

(duration) 2 yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo Clinton Pickett M. D.

(Coroner)

192 (Address) 1536 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 23 1924

20 UNDERTAKER: Samuel Hemsley — ADDRESS 1138 Druid

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7336 Red

D 36194

100-001

D 36194

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hildebrand

(a) RESIDENCE NO. 1816 N Duncan ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 28 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		14		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Hildebrand

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Genevieve Salisbury

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19. 1924. to April 22. 1924.
that I last saw him alive on April 22 1924,
and that death occurred, on the date stated above, at 3.30 a. m.
The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Pneumococcus meningitis

(duration) ..... yrs. ..... mos 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) R. A. Wesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Baltimore Cemetery	4/23 1924
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH PEN AND INK—THIS

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86195

CERTIFICATE OF DEATH.

129 D 86195

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 727 - E. - 20th St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Powers.

(a) Residence No. 727 - E. - 20th St. St., ... Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret L. Powers.

6-DATE OF BIRTH (month, day and year) 4/9/1863

7-AGE. 60 yrs. 4 mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Brooklyn N.Y.

PARENTS.

10-NAME OF FATHER, John Powers.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Brooklyn N.Y.

12-MAIDEN NAME OF MOTHER, Ella. Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Brooklyn N.Y.

14- (Informant) Mrs. M. Byrne

(Address) 727 - E. 20th St.

APR 23 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 20 1924.

17- I HEREBY CERTIFY, That I attended deceased from December 25th 1923 to April 20th 1924 that I last saw him alive on April 19 1924, and that death occurred, on the date stated above, at 12 10 Am. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 1 yrs. 15 mos. 27 ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analyses

(Signed) E. E. Jelly M. D.

April 24 1924 (Address) 806 E. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	April 23 1924
20-UNDERTAKER,	ADDRESS
Geo. F. Ruth	1735 Harford Ave

CAUSE OF DEATH. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Every item should be carefully supplied. Exact statement of OCCUPATION is very important. See forms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See forms, so that it may be properly classified. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

36196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 86196

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1309 Harford Ave. St., 9 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Stiebler

(a) Residence No. 1309 Harford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? ...yrs. ...mos. ...ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Frances Stiebler

6-DATE OF BIRTH (month, day and year) Aug 10 1849

7-AGE. 74 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: News paper
(b) General nature of Industry, business, or establishment in which employed (or employer): carrier-Oil
(c) Name of employer:

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER. Frederick Stiebler

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country).

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) Not Known (State or Country).

14- (Informant) Mrs Frances Stiebler

(Address) 1309 Harford Ave

15- APR 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 19 1924 to Apr. 21 1924

that I last saw him alive on Apr. 21 1924

and that death occurred, on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Not definite yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cancer

(Duration) ...yrs. ...mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examinati

(Signed) Benj. F. Hayden M. D.

4/22/ 1924 (Address) 1116 N. Carolina Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Dark Town Cemetery — DATE OF BURIAL: April 24 1924

20-UNDERTAKER, Henry Hoerle & Son — ADDRESS 1301 E Eager St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 86197 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86197

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1840 E. North Ave St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmund C. Fahlen

(a) Residence No. 1840 E North Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of ~~[illegible]~~ WIFE of Isabella Fahlen

6-DATE OF BIRTH (month, day and year) Nov. 17 186[illegible]

7-AGE. 61 yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of Industry, business, or establishment in which employed (or employer) Employed at American Refrigerator
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Carl C. Fahlen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Josephine Ohlendorf

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Isabelle Fahlen
(Address) 1840 E North Ave

15- Filed APR 23 1924 ROBERT R. KRAUTER, Registrar.
Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1924 to April 21 1924
that I last saw him alive on April 21 1924
and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

1 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1923
Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E Gil Hall M. D
Apr 22 1924 (Address) 1631 E North Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Parkwood Cemetery — DATE OF BURIAL. April 24 1924

20-UNDERTAKER, Henry Hoech Son — ADDRESS 1901 E Eager St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86198 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86198

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Aldridge Matthews

(a) RESIDENCE No. 5-W-Preston ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 70 yrs. 5 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dennis M. Matthews

6 DATE OF BIRTH (month, day, and year) Oct 29 1853

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Charlestown (State or country) W. Va.

PARENTS

10 NAME OF FATHER Andrew Aldridge

11 BIRTHPLACE OF FATHER (city or town) Charlestown (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mayant Green

13 BIRTHPLACE OF MOTHER (city or town) Charlestown (State or country) W. Va.

14 Informant Mr. J. Mark Matthews (Son)

(Address) 4105 Ivanway-Guilford-City

15 Filed APR 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22 1924

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1924, to April 22, 1924, that I last saw h[illegible] alive on April 24, 1924, and that death occurred, on the date stated above, at 4 35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) Henry U. P. Wilson, M. D., M. D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlestown, W. Va. DATE OF BURIAL Apr 25 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

T 193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86199

CERTIFICATE OF DEATH.

101-001 D 86199

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Arthur

(a) RESIDENCE NO. 612 S. Eutaw ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rose Arthur

6 DATE OF BIRTH (month, day, and year) January 3rd 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hunter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER John F. Arthur

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Annie Goodnow

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

Filed APR 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to April 21, 1924, that I last saw him alive on April 21, 1924, and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Rt Lung Right Lower Lobe)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Pneumococcus Infection Septicemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) I. E. Robertson, M. D.

4/21, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	April 24 24
20 UNDERTAKER Lilly & Zeiler	ADDRESS 409 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86200

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 86200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Brown

(a) RESIDENCE NO. 2204 Eastern Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year) Dec 27, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Capping Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER George Bangert

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Amelia Wilke

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Augusta Roseke

(Address) 2204 Eastern Ave

15 APR 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 21, 1924, that I last saw her alive on April 21, 1924, and that death occurred, on the date stated above, at 12 55 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ... yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A A Sussman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	4/24/24
20 UNDERTAKER Philip Henrig	ADDRESS 2016 Orleans

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state

WRITE PLAINLY, WITH UNFADING INK—

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86201

CERTIFICATE OF DEATH.

1882 D 86201

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Patapsco Ave & 6th St. ST., Brooklyn WARD) 25

2-FULL NAME Frank Linsenmeyer.

(a) RESIDENCE NO 608 Patapsco Ave. Brooklyn. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 3, 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Linsenmeyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Drescher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Frank Schmidt (brotherinlaw)
(Address) 614 Patapsco Ave. Brooklyn

15 Filed APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the body.
Accidentally run over by car #5514
of the U. Ry. & E. Co.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

April 22, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	Apr 23 1924
20 UNDERTAKER E. & B. Hartle	ADDRESS 1056 West Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86202

CERTIFICATE OF DEATH.

101-80 D 86202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2324 Essex ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOHN BANASZKIEWICZ,

(a) RESIDENCE NO. 2324 Essex ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Widowed,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Banaszkiewicz,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 640

(b) General nature of industry, business, or establishment in which employed (or employer) Day laborer,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER ------ Banaszkiewicz,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant George Banaszkiewicz (Address) 2324 Essex Street

15 Filed APR 23 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20 - 1924, to April 21 - 1924.

that I last saw him alive on April 21 1924

and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) x yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. P. Neu, M. D.

4/23/24 (Address) 4085 Pat Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ST. STANISLAUS CEMETERY	Apr. 25- 1924
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86203

11-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 249 W. Hoffman St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vrania Williams

(a) Residence No. 249 W. Hoffman St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Col -

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Williams

6-DATE OF BIRTH (month, day and year): June 10-1881

7-AGE: 43 yrs. 10 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va.,

PARENTS.

10-NAME OF FATHER: John Perkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Mary Ellis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va.,

14- (Informant) Sylvania Williams
(Address) 249 W. Hoffman St.

15- Filed APR 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 20-1924

17- I HEREBY CERTIFY, That I attended deceased from Feby 29 1924 to April 20, 1924 that I last saw her alive on April 19, 1924 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Grippe

(Duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(Duration) — yrs. — mos. 29 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. N. Pettekan, M. D.

, 19 (Address) 817 Hamilton Ter

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	April 23 1924
20-UNDERTAKER.	ADDRESS
Wm. R. A. Elliott	1725 Ashland Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

CD 86204 HEALTH DEPARTMENT—CITY OF BALTIMORE Bailey CD 86204

CERTIFICATE OF DEATH.

REGISTERED NO. 8 118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N Wolfe ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Baily

(a) RESIDENCE. NO. 1212 N Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Bailey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Frisby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Florence Fortheringham
(Address) 1212 N Wolfe

15 Filed ....., 19 .....

APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to Apr 20, 1924, that I last saw h[illegible] alive on Apr 20, 1924, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Intussusception Bowels
& Gastritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Lloyd Burns, M. D.

4-24-24 19 (Address) 701 E 22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr 23 1924
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	725 Eastland Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S. Streeper ST.; 1 WARD).

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Zamenski

(a) RESIDENCE. NO. 617 S Streeper ST. 1 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 63; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant Stanislaus Zamenski

(Address) 617 Streeper St

15 Filed APR 23 1924 HUBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20 1924 to April 21 1924, that I last saw him alive on April 21 1924, and that death occurred, on the date stated above, at 1.40A m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Ryvanek, M. D.

(Address) 617 S Streeper St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem — DATE OF BURIAL: 4-25- 1924

20 UNDERTAKER: Kopiec & Frankowski — ADDRESS: Fleet St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86206

101-001

D 86206

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital No

CITY OF BALTIMORE: (No. ... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Mook

(a) RESIDENCE NO. Colgate Md. ST., / WARD

(Usual place of abode) 127 29th St.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 1 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Boston (State or country) Mass

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) — (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) —

14 Informant Wm Nickols
(Address) Colgate, Md.

15 Filed APR 23 1924 Burial Permit Issued ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 1 ds.

Exhaustion

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

(Signed) Geo Lincoln Blake M. D.

(Coroner)

192 (Address) 1436 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loved Heart Cem	4-23 1924
20 UNDERTAKER	ADDRESS
Stephen Brackowsky	100 S Monroe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86207

CERTIFICATE OF DEATH.

154-003

D 86207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST. (or) 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Goldman

(a) RESIDENCE NO. 3624 Cottage Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7 mos.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (all)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ethel Abel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Goldman
(Address) 3624 Cottage Ave

15 Filed APR 23 1924 19.. HUBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-1924

17

I HEREBY CERTIFY, That I attended deceased from 4-21-, 1924, to 4-23-, 1924.

that I last saw him alive on 3 o'clock 4-23 1924,

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Heart failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Postoperative Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-22-24.

Was there an autopsy? Yes X

What test confirmed diagnosis?

(Signed) Adler Goldman, M. D.

4/23 1924 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd.	4/23 1924
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Baltimore

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56

D 86208

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Rosebury ST., 15 WARD)

2-FULL NAME John Robinson

(a) RESIDENCE NO 1709 Rosebury ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1 1924 Infancy

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Infant Child

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown Md

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown Md

14 Informant John Robinson
(Address) 1709 Rosebury St

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets

(Duration) ..... yrs. ..... mos 21 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo C. Radcliffe, M. D.
(Coroner.)

3/30/24, 192 (Address) 1743 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Peace	Mar 25 1924
20 UNDERTAKER	ADDRESS
Samuel W. Nuttle	1345 Pine

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Chia Schoenfield)

D 86209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86209

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chaia Schoenfeld

(a) RESIDENCE No. 1008 E. Baltimore ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon

6 DATE OF BIRTH (month, day, and year) Nuturnm

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yankel Lehmstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lesh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

APR 2 3 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1924

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1924, to April 22, 1924.

that I last saw her alive on April 22, 1924.

and that death occurred, on the date stated above, at 5:45 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) John C. Weber M.D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	4/23 1924
20 UNDERTAKER	ADDRESS
Jack Lewis 1439 E Balto St	

INSTRUCTIONS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 86210

CERTIFICATE OF DEATH.

84

D 86210

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2931 Windsor Ave. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. A. Hibbitts

(a) RESIDENCE NO. 2931 Windsor Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hibbitts (Roche)

6 DATE OF BIRTH (month, day, and year) Feb 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Pat. Hibbitts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Helen Hibbitts

(Address) 2931 Windsor Ave.

15 APR 23 1924 ROBERT P. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1923, to April 21, 1924.

that I last saw him alive on April 20, 1924.

and that death occurred, on the date stated above, at 12.35 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coulahan, M. D.

4/22 19 24 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	4/24 1924
20 UNDERTAKER H. B. Cunningham Son	ADDRESS 517 N. Schroeder St

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86211

CERTIFICATE OF DEATH.

D 86211

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 15 Ward) 73

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mae Laird

(a) Residence No. 3818 Norfolk ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-~~Single~~, Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Robert Laird

6-DATE OF BIRTH (month, day and year) Feb 12 - 1889

7-AGE. 35 yrs. 2 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER Samuel France

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Emma Finnegan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14-

(Informant) Robert Laird

(Address) 3818 Norfolk ave

15-

Filed ..... 192.. ROBERT A. KRAUTER, Registrar.

APR 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 20. 24

17- I HEREBY CERTIFY, That I attended deceased from April 16 19 24 to April 20 19 24

that I last saw h.. alive on April 20 19 24

and that death occurred, on the date stated above, at 2 40 A.M.

The CAUSE OF DEATH* was as follows:

Acute Anterior Poliomyelitis

(Duration) ..... yrs. ..... mos. 28 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) S Goldgeier M. D.

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Cemetery — DATE OF BURIAL. Apr 23, 1924

20-UNDERTAKER. Harry H. Witzke — ADDRESS. 1531 W Lombard St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86212

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 10 Poplar Ave. Overlea St., 27 Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Nathan F. Byrn

(a) Residence No. 10 Poplar Ave. Overlea St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 23 1903

7-AGE. 20 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Nathan Byrn

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Annie Dorn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Annie Dorn Byrnes

(Address) 10 Poplar Ave. Overlea

15- Filed APR 23 1924 192 . ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21st 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 19 1924 to Apr 21 1924

that I last saw h. alive on Apr 19 1924

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D

4/22 1924 (Address) Mapleaue. Belair Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. April 25th

20-UNDERTAKER. Henry Koeck & Son — ADDRESS 1301 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86213

CERTIFICATE OF DEATH.

101-001 D 86213

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE (No. ..... St., 76 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hamelly

(a) RESIDENCE No. 419 S 13th St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER George Hamelly

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Krapp

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed APR 23 1924 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to April 21, 1924, that I last saw him alive on April 21, 1924, and that death occurred, on the date stated above, at 3 50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) X
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. A. Wesch, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL April 23 1924

20 UNDERTAKER Lilly and Zirkin

ADDRESS 402 N. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86214

CERTIFICATE OF DEATH.

D 86214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 E Montgomery St WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D Eberhart

(a) RESIDENCE NO. 207 E Montgomery St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Alice E Eberhart

6 DATE OF BIRTH (month, day, and year) Nov 27 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Delivery Clerk 53

(b) General nature of industry, business, or establishment in which employed (or employer) at B & O.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles W. Eberhart

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Hewett

13 BIRTHPLACE OF MOTHER (city or Kent Co
(State or country) Maryland

14 Informant Mrs Alice E Eberhart
(Address) 207 E Montgomery St

15 Filed APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1924, 19..., to Apr 21 1924, 19...,

that I last saw her alive on Apr 21 24, 19...,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Lesion
Mitral Insufficiency
Renal Insufficiency (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Brights
Renal Insufficiency (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Kolb, M. D.

(Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 24 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

NO. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 86215

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1115 Battery Ave ST., 24 WARD)

2-FULL NAME Theodore W Pruitt

(a) RESIDENCE No. 1115 Battery ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Pruitt

6 DATE OF BIRTH (month, day, and year) 12.30.1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	59	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper 604

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dunkirk Md

PARENTS

10 NAME OF FATHER Edward Pruitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dunkirk Md

12 MAIDEN NAME OF MOTHER Sallie Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dunkirk Md

14 Informant Addie Pruitt
(Address) 1115 Battery ave

15 Filed APR 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to April 21, 1924

that I last saw him alive on April 21, 1924,

and that death occurred, on the date stated above, at 7-P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac delatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G E Buyton, M. D.

4/22, 1924 (Address) 301 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 24 1924
20 UNDERTAKER John F. Denny	ADDRESS 15 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86216

CERTIFICATE OF DEATH.

1901 V

74 D 86216

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3615 Maple Ave St. 12 WARD)

2-FULL NAME Laura E Hutrow

(a) RESIDENCE. No. 3615 Maple Ave St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 26 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Hutrown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Glassman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nora Stauffer

(Address) 3615 Maple Ave

15 Filed 1924 Robert T. Harrison Registrar

R 23 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 17th 1924 to April 17 1924.

That I last saw h[illegible] alive on April 17th 1924.

And that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Typical symptoms

(Signed) H. L. Taylor M. D.

4/24 1924 (Address) 1119 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jones Leem Howard Co	Apl 25 1924

20 UNDERTAKER Chenoweth Son ADDRESS 367 Chestnut Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36217

CERTIFICATE OF DEATH.

450 86217

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 Prospect Ave ST.; Roland Park WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hester B. Roher

(a) RESIDENCE. No. 247 Prospect Ave, Roland Park. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Roher.

6 DATE OF BIRTH (month, day, and year) June 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Elinor Longley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City.

14 Informant George W. Roher. (Address) 247 Prospect ave.

15 Filed . 19 Robert P. Harrison, Registrar

PR 23 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21. 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug - , 1923 , to April 21 , 1924 , that I last saw h[illegible] alive on April 21 , 1924 , and that death occurred, on the date stated above, at 6-45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 8 + mos. ds.

CONTRIBUTORY (Secondary) Rectal Hemorrhages

(duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Ingrowing Margin Rectum

(Signed) M. Gibson Porter, M. D.

4/21 1924 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden.	April 24 1924
20 UNDERTAKER	ADDRESS
C. A. Wiedefeld.	501 E 22 St.

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86218

CERTIFICATE OF DEATH.

90 D 86218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Division ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bloody E. Johnson

(a) RESIDENCE NO. 1718 Division ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	Col	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Leslie Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ..

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ..

14 Informant Leslie Johnson
(Address) 1304 Druid

15 Dec. ..., 192... Robert P. Harrison, Registrar

R 231924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) B & O Rail Company.

(duration) yrs. mos. ds.

(Signed) Geo Edwin Brodd, M. D.
(Coroner)

4/22/1924 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakes Branch Va	Apr 25 1924
20 UNDERTAKER	ADDRESS
Sam'l F. Case Son	1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86219

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86219

182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Curtis Bay. (City) ST., 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Do not know.

(a) RESIDENCE NO Do not know. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred -- yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Do not know.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report S.D.
(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

R 2 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

Missing February 20. 1924. Found

16 DATE OF DEATH (month, day and year) floating April 19-24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning.
Fall from a boat.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

April 21, 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
PUBLIC CEMETERY.	
20 UNDERTAKER	ADDRESS

Commissioner of Health. AUG 23 1924

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation. TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

Body at city morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86220

74001 D 86220

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 621 N. Gaulay St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ray Williams

(a) RESIDENCE NO. 621 N. Gaulay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Unk (Address)

15 Filed APR 3 1924 Robert P. Harrison, Registrar

Thelma Perrett Clark

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Cerebral Hemiplegia)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. K. Resch, M. D. (Coroner.)

4-22, 1924 (Address) 621 N. Gaulay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

DATE OF BURIAL 192 APR 22 1924

20 UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86221

CERTIFICATE OF DEATH.

D 86221

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 16 Ward) 31

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Banjamin Miller

(a) Residence No. 1033 Gilmor st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1894

7-AGE.	If LESS than 1 day,
29 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER. Charles Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Annie Widgon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed 192 Registrar.

APR 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1923 to Apr. 17, 1924

that I last saw him alive on Apr. 17, 1924

and that death occurred, on the date stated above, at 2.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L.A. Lally, M. D

4-19-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
UNIVERSITY OF MARYLAND.	APR 22 1924

20-UNDERTAKER. Commissioner Health, Address

For Mr. E. Kessell.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86222

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Josephine Slater.

(a) Residence No..... Preston & Valley ..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year)

7-AGE, About 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... None

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

12-BIRTHPLACE OF MOTHER (city or town)..... (State or Country),

14- (Informant)... Sister Florence.....

(Address)... Preston & Valley.....

15- Filed ....., 19.....

Robert P. Harrison, Registrar.

APR 23 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 22/24

17- I HEREBY CERTIFY, That I attended deceased from April ....., 19....., to ....., 19.....,

that I last saw h.. alive on ....., 19.. ..,

and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ..... yrs. ..... mos. 1 day ds.

CONTRIBUTORY (Secondary) Coma

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F A Warner, M. D.

4/23/24. 19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cathedral	April 23, 1924

20-UNDERTAKER,	ADDRESS
J. C. Windfield	514 Fremont Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86223

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D 86223

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2702 Hudson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Seredez

(a) Residence No. 2702 Hudson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 8 1921

7-AGE. 2 yrs. 9 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Peter Seredez

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Lillian Gardzelewski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14-

(Informant) Mrs Lillian Seredey

(Address) 2702 Hudson St

15-

Robert F. [illegible]

APR 23 1924 192

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 23 1924

17- I HEREBY CERTIFY, That I attended deceased from April 19, 1924 to April 23 1924

that I last saw h.er alive on April 23, 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) .....yrs. mos. 26 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton M. D.

4/23, 1924 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Stanislaus	Apr 25 1924.
20-UNDERTAKER.	**ADDRESS**
M J. Sadowski.	705 S. Ann St

INSTRUCTIONS.—Every item of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86224

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 001 ✓ D 86224

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Schmidt

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 ... 19 Robert E. Harrison, Registrar

Burial Permit Clerk

R 2 31924.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-10, 1924, to 4-16, 1924 that I last saw her alive on 4-15, 1924 and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude G. Bruce, M. D.

4-16 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville DATE OF BURIAL 4/22 1924

UNDERTAKER H. Clay Glover ADDRESS 915 Eutaw

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every question must be answered, and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86225 ✓

D 86225

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 E Barney ST. 23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey Estella Hawkins

(a) RESIDENCE NO. 37 E Barney ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas Hawkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Clara Gantz

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Chas Hawkins
(Address) 37 E Barney

15 Filed ..... 19 .....
Registrar

R 231924

Robert F. [illegible]
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924 to April 23, 1924
that I last saw her alive on April 23, 1924
and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Hawkins M. D.

4/23, 1924 (Address) 2 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	4/25 1924
20 UNDERTAKER	**ADDRESS**
J. F. Oakey & Sons	318 Light St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86226

CERTIFICATE OF DEATH.

84 D 86226

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Overland ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Goedeke

(a) RESIDENCE No. 2819 Overland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 9 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Frank Goedeke

6 DATE OF BIRTH (month, day, and year) July 13th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bernard Hartung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ackerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Goedeke

(Address) 2819 Overland ave

15 Robert P. Harris, Registrar

R 23 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 23 1924

17

I HEREBY CERTIFY, That I attended deceased from apr 22, 1924, to apr 23, 1924, that I last saw h[illegible] alive on apr 22, 1924, and that death occurred, on the date stated above, at 1245 a, m.

The CAUSE OF DEATH* was as follows:

angina Pectoris.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John L. Donahoe, M. D.

, 19 (Address) 1714 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL April 25th 1924

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86227

CERTIFICATE OF DEATH.

D 86227

1-PLACE OF DEATH Maryland General Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Robert Howell

(a) RESIDENCE NO. 1220 W. Lexington ST., ... WARD St. Michaels Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER W. D. Howell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Howell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Patient
(Address)

R 2 5 1924 ..... 19 Robert F. Carter, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-15-24, 19..., to 4-21-24, 19...,

that I last saw him alive on 4-21-24 19...,

and that death occurred, on the date stated above, at 8 05 0 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Immediate Cause

(duration) yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 4-19-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Jno A Young Jr M. D.

, 19 (Address) 1400 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Cemetery St. Michaels Md	April 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1631 W Lexington St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86228

CERTIFICATE OF DEATH

8 122092

D 86228

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Oliver ST., ... WARD)

2-FULL NAME Rebecca Hoard

(a) RESIDENCE NO. 1743 Oliver ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Hoard

6 DATE OF BIRTH (month, day, and year) March 17-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	67	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Ranecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Hoard (Address) 1743 Oliver St

15 Robert F. ..., 19 ....

Burial Permit Clerk. Registrar

R 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21- 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 29- 1924, to April 21- 1924.

that I last saw h[illegible] alive on April 21- 1924,

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

chronic liver -

about 3 yrs. — mos — ds.
(duration)

CONTRIBUTORY (Secondary) anaemia

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no —

What test confirmed diagnosis? —

(Signed) Edward Briner M. D.

(Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Emmanuel Cemetery	April 24
20 UNDERTAKER	**ADDRESS**
Geo M. Tinkham & Son	111 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86229

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86229

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorcas Topper

(a) RESIDENCE NO. 25 Hanover St. Hanover, Pa. ST., WARD Hanover Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover Pa.
(State or country)

PARENTS

10 NAME OF FATHER Vincent J. Topper

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Flora Topper

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Vincent J Topper
(Address) Hanover Pa.

PR 2 3 1924 . 19 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1924, to April 23, 1924,

that I last saw her alive on April 23, 1924,

and that death occurred, on the date stated above, at 1 20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Hanover Pa.

Did an operation precede death? Yes Date of 4/20/24

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) Geo B. Dyberst, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover Pa	April 25 1924
20 UNDERTAKER	ADDRESS
M. J. Sullivan Son	Hanover

INK—THIS IS A PERMANENT RECORD. Every ... of information should be stated EXACTLY. AGE ... should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 86230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86230

CERTIFICATE OF DEATH.

31

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2504 Woodbrook Ave WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Anna C Meister

(Residence in Baltimore: No. 2504 Woodbrook Ave S. 46 yrs., 3 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, ~~WIDOWED, OR DIVORCED,~~ (Write the word.) married

6-DATE OF BIRTH, January 5, 1878. (Month) (Day) (Year)

7-AGE, 46 yrs. 3 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) 037

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm H. Thompson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Agusta Gore

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Meister

(Address) 2504 Woodbrook Ave.

15- Robert P. Harrison, Registrar.

APR 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 22, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 2 1924 to Apr 22 1924 that I saw her alive on Apr 22 1924 and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. O. Clozy M. D.

Apr 22, 1924 (Address) 7732 Euton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. London Park Cem. DATE OF BURIAL. Apr 25 1924

20-UNDERTAKER. Wm Thickens Son ADDRESS Govans Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86231

HEALTH DEPARTMENT—CITY OF BALTIMORE

10 D 86231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, (No. 5004 Elmer Av St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Malcolm Conner Jr.

(a) Residence No. 5004 Elmer St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 10th 1918

7-AGE. 5 yrs. 8 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md

PARENTS.

10-NAME OF FATHER Robt M Conner Sr

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country) Md

12-MAIDEN NAME OF MOTHER Lena B Schmuck

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country) Md

11-

(Informant) Robt M Conner

(Address) 5004 Elmer Ave

15-

Filed 19 Robert P. Harrison, Registrar.

APR 23 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 23-1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 10 1924 to Apr 23 1924

that I last saw him alive on Apr 22 1924

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. 9 mos. 9 ds.

CONTRIBUTORY (Secondary) Post diphtheria Toxemia

Quadriplegia Paralysis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam Culture

(Signed) John A Pickard M. D.

4/23 1924 (Address) 1219 Eastland Court

*State the Disease Causing Death, or In deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Woodlawn	
20-UNDERTAKER. H E Lummis	ADDRESS Town

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86232

CERTIFICATE OF DEATH.

100-00 D 86232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 708 W Barney ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Reinhold

(a) RESIDENCE NO. 708 Barney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 9 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Matthew P Reinhold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Stella Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Matthew Reinhold

(Address) 708 W Barney St

15 Robert P. Harrison, Registrar

Burial Permit Clerk

R 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1924

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to April 24, 1924, that I last saw her alive on April 24, 1924 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. V ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Suspected

(Signed) D Harrison, M. D.

April 24, 1924 (Address) 708 W Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL April 24 1924

20 UNDERTAKER H J Schuppius

ADDRESS 1316 Eutaw Pl

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86233

CERTIFICATE OF DEATH.

31 D 86233

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 W Franklin ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel Elizabeth Smith.

(a) RESIDENCE. NO. 1706 W Franklin ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lester Smith.

6 DATE OF BIRTH (month, day, and year) Aug 23, 1900

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wife. 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Daniel E. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Anna Rebecca Rozzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Centreville Md

14 Informant: Delia Smith.
(Address) 1214 Druid Hill Ave.

APR 24 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1924 to April 21, 1924, that I last saw h[illegible] alive on April 19, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pleurisy. Exudative Bronchitis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

April 22, 1924 (Address) 1209 Pennsylvania Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Apr 25 1924
UNDERTAKER: Samuel J. Wamsley	ADDRESS 570 N Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86234

11-002 D 86234

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 Hartford Ave ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addison Watkins

(a) RESIDENCE NO. 835 Hartford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 58; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Nellie Wells

(Address): 831 Stanford Ave.

15 Filed APR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Apl 9th, 1924, to Apl 22nd, 1924, that I last saw h[illegible] alive on Apl 22nd, 1924, and that death occurred, on the date stated above, at 5.00 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 607 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem. DATE OF BURIAL: Apr 24 1924

20 UNDERTAKER: Samuel S Hemsley ADDRESS: 1338 Bridle

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

123 86235

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 9 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie May Scott

(Residence in Baltimore: No. 1513 Lamont Ave St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. Apr. (Month) 27 (Day) 1871 (Year)

7-AGE. 57 yrs. 11 mos. 26 ds.

If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Wm. E. Casey

11-BIRTHPLACE OF FATHER, (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary Casey.

13-BIRTHPLACE OF MOTHER, (State or Country), England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Olson

(Address) 1513 Lamont Ave

15- FILED APR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. (Month) 22 (Day) 24 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

Fatal Coma

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D.

Apr 24 1924 (Coroner.) (Address) 1513 Lamont Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State. Lifetime yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Parkwood Cemetery

DATE OF BURIAL. 4/25 1924

20-UNDERTAKER. George J. Ruth

ADDRESS 1935 Hartford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-24—M&T—1500 Blks.

D 86236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 86236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2960 Harford Road ST., 9 WARD)

2-FULL NAME Nellie B. Clancey

(a) RESIDENCE NO. 2960 Harford Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 23, 1900

7 AGE: Years 24 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk. 09

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Clancey.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Hannah Fogg.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mr. John Clancey. (Address) 2960 Harford ave

15 Filed APR 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1923, to Apl 22, 1924, that I last saw her alive on Apl 22, 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. J. Kinzey, M. D.

(Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 4/26 1924

20 UNDERTAKER: George J. Ruth

ADDRESS: 1737 Harford Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1702 D 86237 — 94 D 86237

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Clutt

(a) RESIDENCE NO. 1237 Central Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	6	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Clutt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Relative JOHNS HOPKINS HOSPITAL

15 Filed APR 24 1924, 19 ..... Burial Permit ..... Registrar ROBERT F. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1924, to April 23, 1924, that I last saw him alive on April 23, 1924, and that death occurred, on the date stated above, at 6 80 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Neck
Acute Cervical Adenitis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jas. R Bugg 9 M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL 4/24 1924

20 UNDERTAKER: George J Ruth 1735 — ADDRESS Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86238

CERTIFICATE OF DEATH.

90 D 86238

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 S Spring ST. 3 WARD)

2-FULL NAME William Braddaw.

(a) RESIDENCE NO. 504 S. Spring ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35.	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Baugh Fertilizer Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Braddaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant St Joseph Hospital Record
(Address)

15 Filed APR 24 1924, 19.. ROBERT R. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1924, to April 21, 1924.

that I last saw him alive on April 21, 1924,

and that death occurred, on the date stated above, at 3 30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Valvular endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Schumm, M. D.

, 19 (Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery. DATE OF BURIAL April 24 24

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.—400 Bks.

D 86239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86239

1-PLACE OF DEATH

City of BALTIMORE: (No. 2217 Poplar Grove St., 15 Ward)

Registered No. 001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John George Fetting

(a) Residence No. 2217 Poplar Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Wheatley

6-DATE OF BIRTH (month, day and year) Dec. 14, 1855

7-AGE. 68 yrs. 4 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Fetting

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophie Meyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. John Fetting

(Address) 2217 Poplar Grove St.

15- APR 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 22-24

17- I HEREBY CERTIFY, That I attended deceased from July 30 1918 to Apr 22 1924

that I last saw him alive on Apr 22 1924

and that death occurred, on the date stated above, at 3-25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ✓ yrs. ✓ mos. 4 ds

CONTRIBUTORY (Secondary) Arteri sclerosis & Bright's Disease

(Duration) 5 yrs. 9 mos. ✓ ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Fetting, M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge Cemetery	4/25 19 24
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D 86240

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 768 W Mulberry ST., 4 WARD)

2-FULL NAME Lucy Ann Woodson

(a) RESIDENCE NO. 768 W mulberry ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: E.R. Woodson

6 DATE OF BIRTH (month, day, and year): Aug. 1866

7 AGE: Years 58; Months 7; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Co. Hampton Co. Va.

PARENTS

10 NAME OF FATHER: Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Adeline Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: James A Woodson

(Address): 768 W mulberry St (town)

15 Filed APR 24 1924 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/22/1924

17

I HEREBY CERTIFY, That I attended deceased from 4/20/, 1924, to 4/22, 1924.

that I last saw her alive on 4/22, 1924,

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

Personal knowledge (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. Jackson, M. D.

4/22 1924 (Address) 808 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk Va

DATE OF BURIAL: 4-24 1924

20 UNDERTAKER: David Easton

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86241

CERTIFICATE OF DEATH.

3/D 86241

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 16 WARD)

2-FULL NAME Blanche Green

(a) RESIDENCE NO. 1014 Parrish ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mary Bacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Cecelia Beck
(Address) 1014 Parrish St

15 Filed APR 24 1924, 192... ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Autposy at Hopkins Hosp)
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Wallen, M. D.
(Coroner.)

Apr 23/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-24 1924
20 UNDERTAKER Dan'l Carton	ADDRESS 916 Ca av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86242

CERTIFICATE OF DEATH.

31 ✓ D 86242

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Gray

(a) Residence No. 810 Warner st. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Gray

6-DATE OF BIRTH (month, day and year) 1901 ?

7-AGE.	If LESS than 1 day,
23? yrs. mos. ds.	hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laundress 04

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joe Gray

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ida Mason

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- APR 24 1924 ROBERT R. KRAUTER, Registrar.

16- Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 22 1924 to Apr. 23 1924 that I last saw her alive on Apr. 23 1924 and that death occurred, on the date stated above, at 1.45 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. L. Lally, M. D

4-23 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Island Creek Church	4-26 1924
20-UNDERTAKER, Calvert Co. Md	ADDRESS 142

John H. Toadvin

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86243

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 86243

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Calvert

(a) Residence No. 905 Bennett Place St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 80 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stone Cutter

(b) General nature of Industry, business, or establishment in which employed (or employer) Q'S

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) " (State or Country), " "

14-Informant Mrs. Mollie Calvert

(Address) 905 Bennett Place

15-

Filed 1924 ROBERT R. KRAUTER, Registrar.

APR 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-24-1924

17- I HEREBY CERTIFY, That I attended deceased from 3-26 1924 to 4-24 1924

that I last saw him alive on 4-24 1924

and that death occurred, on the date stated above, at 1.45 AM

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Carcinoma Prostate ?

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Idea

(Signed) H O Harper, M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Olivet — DATE OF BURIAL, April 26, 1924

20-UNDERTAKER. Robert Brothers — ADDRESS Calhoun & Hollins

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86244 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-007 D 86244

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 114 S. Cary St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Lockard

(Residence in Baltimore: No. 114 S. Cary St.; yrs....mos....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	Single

6-DATE OF BIRTH. Dec (Month) 24 (Day) 1913 (Year)

7-AGE. ....yrs. 3 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. George Lockard

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Madeline Bloom

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Lockard

(Address) 114 S Cary St

15. Filed APR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 23 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental asphyxiation when a sheet in bed was pulled around

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M Hanlon M. D. (Coroner.)

April 23 1924 (Address) 714 E Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 4/25 1924

20-UNDERTAKER, Robert Brooks & Son ADDRESS Cor Calhoun & Hollins Sts

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-D 86245

D 86245

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 600 Ravenswood Ave. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John or Jean Tag.

(a) RESIDENCE. No. 600 Ravenswood Ave. ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Tag

6 DATE OF BIRTH (month, day, and year) Aug 1st 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Daniel Tag

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Schwiendt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Tag

(Address) 600 Ravenswood ave

15 Filed APR 24 1924 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1924

17

I HEREBY CERTIFY, That I attended deceased from April 17th 1924, (to) April 21st 1924, that I last saw him alive on April 21st 1924, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical observation.

(Signed) Wm Edward Cooke, M. D.

19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	4/24/24
20 UNDERTAKER	ADDRESS
Geo Koba & Son	2503 Edmondson ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

176 315 86246 — 100-001 — D 86246

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Cotter

(a) RESIDENCE NO. Chesco Park, Md ST., BACK RIVER WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 20, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	—	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Roy Cotter

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER Mame Burkhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 [illegible]

APR 24 1924

ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to April 23, 1924, that I last saw h... alive on April 23, 1924, and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H H Wirch, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart. DATE OF BURIAL: April 25, 24

20 UNDERTAKER: Jos. J. Kerr ADDRESS: 156 N. Luzerne ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86247

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME Marie Ruley

(a) RESIDENCE No. Edgewood Park-Rosborough Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W Cuta	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 30 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER William Ruley

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Peasley

13 BIRTHPLACE OF MOTHER (city or town) Del.
(State or country)

14 Informant.....
(Address)

15 Filed APR 24 19[illegible] ROBERT R. KRAUTER, Registrar

Burial P...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 22, 1924, to Apr 23, 1924, that I last saw h[illegible] alive on Apr 23, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 35 ds.

CONTRIBUTORY (Secondary) Septicemia Multiple ab- scess

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Home 4/17/24

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo. R Bunn, M. D.

19 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks	April 25 1924
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 L. Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86248

86248

CERTIFICATE OF DEATH

100-001

1-PLACE OF DEATH Bay View Hospital & Registered No.

City of BALTIMORE: (No. St. Ward) (If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Charles Milton Cole

(a) Residence No. 1607 Patterson Pk. Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Dec 28 1853

7-AGE. 71 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Gen Hosp

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Mary Land

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14-INFORMANT Bay View Hospital

(Address) Baltimore, Md.

15-FILED APR 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 23, 1924

I HEREBY CERTIFY, That I attended deceased from April 2, 1924 to April 23, 1924

that I last saw h. alive on April 22, 1924

and that death occurred, on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Contrib)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hay Chronic with Cerebral Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Fred Smith M. D.

4/23/1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	Apr 26 1924
20-UNDERTAKER.	ADDRESS
Wm Cook & Son	504 E Monument Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86249

188-003 D 86249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital St. 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Milnor Rennie

(a) RESIDENCE NO. 3214 W. 27th St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11 yrs	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School pupil
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER James Rennie

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Catherine [illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore, Md.

14 Informant James Rennie
(Address) 3214 W. 27th St

15 Filed APR 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Auto Accident accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison, M. D.
(Coroner.)

April 23, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL April 24, 1924

20 UNDERTAKER Wm Cook & Son — ADDRESS E Monument Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86250

CERTIFICATE OF DEATH.

16 4 D 86250

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3400 Toone St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Goodwin

(a) Residence No. 3400 Toone St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James Goodwin

6-DATE OF BIRTH (month, day and year) April 20-1845

7-AGE. 79 yrs. 0 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, James Bamber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14- (Informant) Mrs. May B. Lidard

(Address) 3400 Took St.

15- APR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 22-1924

17- I HEREBY CERTIFY, That I attended deceased from ....., 1915 to April 22, 1924

that I last saw h.r alive on April 20, 1924

and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Senility Age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Smith, M. D.

April 23, 1924 (Address) 1182 Calhoun St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, April 25, 1924

20-UNDERTAKER, Jinkler & Jinkler — ADDRESS 1739 E. Eager St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 86251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 609 N. Caroline St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Nancy Curry

(a) Residence No. 609 N. Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 9, 1890

7-AGE. 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md. Easton,

PARENTS.

10-NAME OF FATHER, John H. Weldon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Annie Campbell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mrs. Annie Green

(Address) 609 N. Carolina St.

15- Filed APR 24 1924 19.. Burial Permit Issued ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 20 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 9, 1923 to Apr 20, 1924 that I last saw h.. alive on Apr 20, 1924 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Edward Fisher M. D.

(Address) Apr 23 1924 1612 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Asbury Cem.	Apr. 24, 1924
20-UNDERTAKER. Wm J. S. Locke	ADDRESS 1302 Jefferson St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86252

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 McCubbin ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Chocolate

(a) RESIDENCE NO. 1718 McCubbin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work R.R. Employee
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel
(c) Name of employer Co. 013

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bnknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant P. Morton Chase
(Address) 1400 Mosher St. KRAUTER

15 Filed APR 24 1924 Burial Permit Clerk.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Undetermined -(Reported gastric indigestion) yrs. mos. ds.

(Signed) J. [illegible] Cullen, M. D.
(Coroner)

Apr 23 / 24 192 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 25 192 4
20 UNDERTAKER Sam'l M Chase Son	ADDRESS 1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Fuerhard.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-001

D 86253

CERTIFICATE OF DEATH.

D 86253

1-PLACE OF DEATH #

REGISTERED NO. D 86253

CITY OF BALTIMORE: (No. 12 N. Hilton St.: 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Fuerhard

(a) RESIDENCE. No. 12 N Hilton St. WARD. 20th

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. 20 hrs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-22-24

7 AGE	Years	Months	Days	If LESS than 1 day, 20 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 12 N. Hilton Balto Md

PARENTS

10 NAME OF FATHER F. A. Fuerhard

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Catherine Grody

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant (Address) 12 N. Hilton St

15 Filed APR 24 1924 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23- 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-23- , 1924 , to 4-23- , 1924 , that I last saw him alive on at 2 05- , 19 , and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Prematurely delivered
8 mos. old

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) Victor Richards, M. D.

, 19 (Address) 914 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 24 / 1924
20 UNDERTAKER	ADDRESS
F. B. Keppler	223 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86254 001 ✓

74 D 86254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 10 S. Potomac St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Helen Kruse

(a) Residence No. 10 S. Potomac St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ (or) WIFE of Fred Kruse

6-DATE OF BIRTH (month, day and year) Dec 24-1875

7-AGE. 48 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Home
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. August Eggerbrecht

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Schutte

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Fred Kruse

(Address) 10 S. Potomac St

15- APR 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 22 24

17- I HEREBY CERTIFY, That I attended deceased from Apr 20, 19 24, to Apr 22, 19 24

that I last saw h.. alive on Apr 22, 19 24,

and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. V. Mengel, M. D.

4/23, 19 24 (Address) N 38 E Biddle.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem — DATE OF BURIAL, 4/26/24

20-UNDERTAKER. J. A. Moran — ADDRESS 300 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86255

CERTIFICATE OF DEATH.

90 D 86255

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 N Calvert St., 12 WARD)

2-FULL NAME Lippomo-Fravadini

(a) RESIDENCE NO. 717 Hillen Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Fravadini

6 DATE OF BIRTH (month, day, and year) June 18, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	10	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Ignazio Fravadini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lucia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Sophie Fravadini
(Address) 717 Hillen Ave

15 Filed APR 24 1924 192

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquisition (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Arteriosclerosis yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Geo Blunt Rodes M. D.
(Coroner)
#23rd W (Address) 1436 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	4/25/1924
20 UNDERTAKER	ADDRESS
F C Krauss & Son	703 Hanover

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of DECEASED and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86256

CERTIFICATE OF DEATH.

66

D 86256

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE. (No. 3 St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Warwick alias Michael Ryan

(a) RESIDENCE NO. 1 St. Paul & Hopkins St., WARD Smug Harbor

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer 040

9 BIRTHPLACE (city or town)
(State or country) 4/24/24

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Date APR 24 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

(Signed) G. E. Bates, M. D.
(Coroner.)

4/24/24, 192 (Address) 123 E. Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificate.

1355 THE MORGUE

UNIVERSITY OF MARYLAND APR 24 1924

Commissioner of Health.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 Woodlawn Road ST., Park WARD)

REGISTERED NO. D 86257

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cupid

(a) RESIDENCE No. ..... ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	C.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			4.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER Lothie Cupid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Police Dept.
(Address)

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suffocation
Accidental.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrison M. D.
(Coroner.)

April 7. 1924 (Address) 632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

APR 24 1924 Burial Permit Clerk
1350 THE MORGUE.

APR 24 1924

UNIVERSITY OF MARYLAND
School of Hygiene & Public Health,

6 of

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86258

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH D 86258 5

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Humphrey

(a) RESIDENCE NO. 110 Colvin ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10 NAME OF FATHER ?
11 BIRTHPLACE OF FATHER (city or town) ? (State or country)
12 MAIDEN NAME OF MOTHER ?
13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed APR 24 1924, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1923, to 4-21, 1924
that I last saw him alive on 4-21, 1924
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Myocardial Insufficiency
(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clin.
(Signed) Claude B. Heaps, M. D.
4-21, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health,
APR 24 1924
Fat. Med. Bureau

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

130

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86259

161-001 D 86259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 16 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mayerowitz

(a) RESIDENCE NO. 1032 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 20, 1924

7 AGE — Years | Months | Days | If LESS than 1 day, 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Toledo Ohio

PARENTS

10 NAME OF FATHER Samuel Mayerowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ray Zetzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 19 24

17 I HEREBY CERTIFY That I attended deceased from Apr 20, 19 24, to Apr 20 19 24, that I last saw he alive on Apr 20 19 24, and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Premature Baby - 6½ mo

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Isidor L. Jaffe, M. D.

Apr. 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL Apr 23 19 24

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

128

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86260

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86260

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 N. Eutaw ST.: 11 WARD)

2-FULL NAME William Worrall Dunnett

(a) RESIDENCE. No. 645 N. Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? 82 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Dunnett

6 DATE OF BIRTH (month, day, and year) Jan. 20-1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER David Dunnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Kate Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miller Dunnett

(Address) 645 N. Eutaw St

APR 24 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17

I HEREBY CERTIFY, That I attended deceased from April 18th, 1924, to Apl 23rd, 1924, that I last saw h.im alive on Apl 22nd, 1924, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis &
Genl. Arteriosclerosis
several
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) D W Keown, M. D.

4/24 1924 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 25 1924

20 UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86261

CERTIFICATE OF DEATH.

32

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. My Jew Hospt. ST., 14 WARD)

2-FULL NAME Miss Helena Jews

(a) RESIDENCE NO. 1532 Mt Royal Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Sigle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 27-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Andrew E Jews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jeanette Berkstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant Helena Jews

(Address) 1532 Mt Royal Ave

Filed APR 24 1924, 19 ... Robert P. Harrison, Registrar

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-24

17

I HEREBY CERTIFY, That I attended deceased from 4-14-24, 19... to 4-23-24, 19...,

that I last saw h.. alive on 4-23-24, 19...,

and that death occurred, on the date stated above, at 5-40 p m.

The CAUSE OF DEATH* was as follows:

Meningitis T.B.

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) John A Stamphini, M. D.

(Address) My Jew Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	April 25 1924

20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 86262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL. ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Wright

(a) RESIDENCE NO. 211 N. Amity St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922 -

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Isaac Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sidonia Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: JOHNS HOPKINS HOSPITAL

(Address)

15 Filed APR 24 1924, 19 Robert P. Harrison, Registrar

Burial Permit 61

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1924, to April 21, 1924, that I last saw her alive on April 21, 1924, and that death occurred, on the date stated above, at 5-26 P. m.

The CAUSE OF DEATH* was as follows:

General miliary tuberculosis

Tuberculous Meningitis

(duration) yrs. 0 mos 2 weeks ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Lumbar puncture

(Signed) H. A. Wreck, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 25 1924
20 UNDERTAKER	**ADDRESS**
Edward Bryan	1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ... state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Time of burial extended to Monday April 28/24.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86263

D 86263

J. Fitzgerald Stumpf Asst. Com.

CERTIFICATE OF DEATH.

Registered No. 17 31

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Burley

(a) Residence No. 556 Oxford st. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1878

7-AGE.			If LESS than 1 day.
45 yrs.	mos.	ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer). Unknown

(c) Name of employer. Unknown

040

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. William Burley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Diana Snowden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed 19 Robert P. Harrison, Registrar.

APR 24 1924 Chief Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 7 1923 to Apr. 22 1924

that I last saw him alive on Apr. 22 1924

and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally M. D

4-23 19 24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	April 28 19 24
20-UNDERTAKER. Edward Bryan	ADDRESS 631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86264

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 86264

CERTIFICATE OF DEATH

90

1 PLACE OF DEATH — REGISTERED No. C .....

CITY OF BALTIMORE (No. Forbes Street Arena Cold Spring Lane ST. 17 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME James N. Jones

(Residence in Baltimore: No. 1222 Druid Hill Avenue St.; Yrs. ..... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: August (Month) 31 (Day), 1853 (Year)

7 AGE: 70 yrs. 8 mos. 22 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Coachman - Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Private family

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: James N. Jones

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Jones

(Address) 1222 Druid Hill Avenue

15. Robert P. Harrison, ..., 191.....

Burial Permit Clerk. REGISTRAR

PR 24 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 22nd (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at intervals for several years, 191.. to ....., 191.., that I saw h.. alive on March 20th, 1924 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Chronic Nephritis.
Coronary Sclerosis.

(Duration) several years yrs. ..... mos. ..... ds

Contributory (SECONDARY) Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. T. Lockwood M. D.

April 22, 1924 (Address) 5 E. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mount Auburn Cemetery

DATE OF BURIAL: April 25, 1924

20 UNDERTAKER: John A Bishop & Son

ADDRESS: 1107 Druid Hill Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86265

100 D 86265

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Durham ST., 7 WARD)

2-FULL NAME Doris Coleman

(a) RESIDENCE NO. 1023 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Oct 6/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Fred. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Evelyn Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Elliott 1723 Ashland
(Address)

15 Filed ....., 192 ..... Registrar

R 24 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.), M. D.

Apr 24/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Apr 26 1924

20 UNDERTAKER Mrs R. G. Elliott ADDRESS 1723 Ashland Av

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

D 86266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 86266

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 220 N. Caroline ST., 5 WARD)

2-FULL NAME James Shields

(a) RESIDENCE NO. 220 N. Caroline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Norfolk Va.
(State or country)

PARENTS

10 NAME OF FATHER George Shields

11 BIRTHPLACE OF FATHER (city or town) Val
(State or country)

12 MAIDEN NAME OF MOTHER Mary Harrison

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mary Shields
(Address) Norfolk Va.

15 Filed APR 24 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage-Probably tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Haller, M. D.
(Coroner.)

Apr 24/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	April 25 1924
20 UNDERTAKER Mrs. K. E. Elliott	ADDRESS 925 Eastlander

(Duplicate)

(Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86267

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 86267

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2030 W. Saratoga St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belzie Moore Reese

(a) Residence No. 2030 W. Saratoga St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Noah E. Reese

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: about 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): W. Va

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: ? Richards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant): Noah E. Reese

(Address): 2030 W. Saratoga

15- Filed APR 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Apr. 22 1924

17- I HEREBY CERTIFY, That I attended deceased from April 13 '24 to April 22 '24

that I last saw h[illegible] alive on April 22 '24

and that death occurred, on the date stated above, at 11:25 P m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary): Heart Failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R Davis M. D

19 (Address) 2108 Brookfield Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Woodlawn Cem	Apr 25
20-UNDERTAKER	ADDRESS
Wm J Tickner & Sons	North & Pa

8—WRITE PLAINLY, with ink. PHYSICIANS should state CAUSE OF DEATH EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Ondarf)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86268

CERTIFICATE OF DEATH.

X 20 V D 86268

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Thos G. Ondorf

(a) RESIDENCE NO 811 Forrest Ave ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 hours at Ellicott City How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	.		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J Malick & Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER H. Ondorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Easton Sons
(Address) Ellicott City

15 Filed APR 24 1924, 192 Robert P. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Pelvis + shock

(duration) ..... yrs. 12 hours

CONTRIBUTORY (Secondary) Fell on train

(Signed) ..... M. D.
(Coroner.)

4-24 . 192 4 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Fork Union Virginia

19 PLACE OF BURIAL, CREMATION OR REMOVAL Maurertown Va DATE OF BURIAL Dec. 26 1924

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

mation should be carefully supplied. Avoid ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86269

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2030 Eastern Ave St., 2nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa A. Baker

(a) Residence No. 2030 Eastern Ave St., 2nd Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if of foreign birth? 59 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 8th 1865

7-AGE, 59 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, August Brandt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mrs. Robert Baker

(Address) 2030 Eastern Ave

15-

Filed APR 24 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 22/24

17- I HEREBY CERTIFY, That I attended deceased from February 2, 19 24 to April 22, 19 24

that I last saw h. alive on April 22, 19 24

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac - Valvular Chronic -

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Uremia Lungs —

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Mark C Brenler, M. D.

, 19 (Address) 125 E Biddle —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Dap Lawnton — DATE OF BURIAL, April 26 1924

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2600 Eastern Ave

U. S.—WHITE PENCIL. Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86270

CERTIFICATE OF DEATH.

31 D 86270

1-PLACE OF DEATH

City of BALTIMORE: (No. 603 Washington Blvd 23 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Joseph Miller

(a) Residence No. 603 Washington Blvd St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 4 — 1904

7-AGE. 19 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Leaves do

(b) General nature of Industry, business, or establishment in which employed (or employer) Hat Store

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Herbt L. Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER, Alice Quinn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-(Informant) Mrs Maddie Miller

(Address) 603 Wash. Blvd

15-APR 24 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4 - 24 - 24

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1924 to Apr. 24 1924

that I last saw h.im alive on April 24. 1924

and that death occurred, on the date stated above, at 1145 a m.

The CAUSE OF DEATH* was as follows:

a Acute Bronchopneumonia Hepatization.

(Duration) 9 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Microscopical

(Signed) Thos. Norton M. D.

(Address) 888 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral

DATE OF BURIAL. 4/28. 1924

20-UNDERTAKER. Wm Cook

ADDRESS 501 E North

EXACTLY. PHYSICIANS should state CAU... OF D... Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 86271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 W. Henrietta ST., 23 WARD)

2-FULL NAME Louise Whitfield

(a) RESIDENCE NO. 227 W Henrietta ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, hrs. or min. 1864

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Ben. Jozwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Edith Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Theopold Custis (Address) 227 W Henrietta St

15 APR 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/21 1924, to 4/22 1924

that I last saw h alive on 4/22 1924

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pneumonia

18 Where was disease contracted if not at place of death? 3 days

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Lumsden M. D.

19 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn St — DATE OF BURIAL April 25 1924

20 UNDERTAKER: S. H. Brown & Son — ADDRESS 108 W. Mond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 86272

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 N. Arlington ave ST. 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Justina A. Jones

(a) RESIDENCE. No. 908 N Arlington ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July - 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ezekiel Jones

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Bandel

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mary C Martin
(Address) 908 N Arlington ave

15 APR 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1924

17

I HEREBY CERTIFY, That I attended deceased from March 1924, to April 24 1924,

that I last saw h... alive on April 24 1924,

and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hd. of, Duct and Liv.

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Herbert C. Blake, M. D.

19 (Address) 1214 N. Fulton, Boyd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 26 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86273

CERTIFICATE OF DEATH

52

D 86273

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3511 Norwood Ave ST., Howard Park 28 WARD)

2-FULL NAME Emily Hagerty Howes

(a) RESIDENCE NO. 3511 Norwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Howes

6 DATE OF BIRTH (month, day, and year) May 13 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Smiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Isabella Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant E. Clifton Howes (Address) 3511 Norwood Ave

15 Filed APR 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1924

17

I HEREBY CERTIFY, That I attended deceased from Mch, 1923, to Apr 23, 1924.

that I last saw her alive on Apr 23, 1924

and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Septic (duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Rheumatoid Arthritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) A. C. Bennett, M. D.

Apr 24, 1924 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL April 25 1924

20 UNDERTAKER Archie McMulkin — ADDRESS 223 W Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 74-001

D 86274

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3407 Belair Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Erdman

(a) Residence No. 3407 Belair Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emilie Erdman

6-DATE OF BIRTH (month, day and year) Nov. 16/1860

7-AGE. 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Florist

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balt County

PARENTS.

10-NAME OF FATHER, John J. Erdman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balt County

12-MAIDEN NAME OF MOTHER, Christiana Stough

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balt City

14- (Informant) Emelie Erdman

(Address) 3407 Belair ave

15- Filed APR 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 23d 1924

17- I HEREBY CERTIFY, That I attended deceased from April 16 1924 to April 23 1924

that I last saw h.. alive on April 23 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration)..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

.....(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Wm J Kyoaver M. D

April 25 1924 (Address) 801 N Calvert St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem DATE OF BURIAL. April 26, 1924

20-UNDERTAKER. Frank A. Fink ADDRESS 910 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All questions should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86275 — 90 D 86275 — Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3211 Mc Elderry St St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Martin F. Willinger

(a) Residence No. 3211 Mc Elderry St St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Feb 10th 1909

7-AGE.	If LESS than 1 day,
15 yrs. 2 mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Martin Willinger

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Bertha Lentz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

11- (Informant) Bertha Willinger

(Address) 3211 Mc Elderry St

15- Filed APR 25 1924 ROBERT R. KRAUTER, Registrar. ..... Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 23/24

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28 — 1923, to Apr. 22 — 1924 that I last saw him alive on April 22 — 1924 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Heart disease, Mitral

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) — yrs. — mos. 14 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D

4/24/1924 (Address) 1223 N. Carolina St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cem	April 26, 1924
20-UNDERTAKER.	ADDRESS
Frank A. Fink	910 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

86276

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002
D 86276

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1932 E Chase ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy E Alls.

(a) RESIDENCE. No. 1932 E Chase st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of John P. Alls.

6 DATE OF BIRTH (month, day, and year) Dec 25 - 44

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Howard Alls
(Address) 932 E. Chase

15 Filed APR 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1924, to Apr. 23, 1924, that I last saw her alive on Apr 22, 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White M. D.

4/23, 1924 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem'y	April 25 1924
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 86277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2217 Hargrave alley WARD 17)

2-FULL NAME Joseph Tracy

(a) RESIDENCE No. 2217 Hargrave al WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Mal	C.	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/16/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	15	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Cumberland Delany

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Annie Tracy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Annie Tracy
(Address) 2217 Hargrave alley

15 Filed APR 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to April 21, 1924.

That I last saw h alive on April 20, 1924,

and that death occurred, on the date stated above, at 5-0 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) General Epidemic

(duration) 7 yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Fred. P. Hall, M. D.

, 19 (Address) 426 E 23 d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamel Cemetery — DATE OF BURIAL April 25 1924

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1725 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86278

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Linden ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lloyd Sawyer

(a) RESIDENCE NO. 1014 Linden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Sawyer

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Adam Sawyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Pearl Oden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant Pearl Sawyer (Address) 1014 Linden Ave

15 Filed APR 25 1924 ROBERT R. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 8, 1924, to Apr 23, 1924.

that I last saw him alive on Apr 21, 1924,

and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

Signed) William E Burton, M. D.

4/23 1924 (Address) 762 Wolfe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Lot DATE OF BURIAL 4-26 1924

20 UNDERTAKER Mark G. Elliott ADDRESS 1720 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86279

161-001

D 86279

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Stulfish

(a) Residence No. 90 Roland Ave St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	W.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 4-24-1924

7-AGE.	If LESS than 1 day.
.....yrs.....mos.....ds.	3 hrs. or 30 min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER, Wm Stulfish

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va.

12-MAIDEN NAME OF MOTHER, Carrie Oldham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Stulfish

(Address) 90 Roland Ave City

15- APR 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 24 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 24 - 1924 to Apr. 24 1924

that I last saw h.im alive on Apr. 24 1924 1.30 P m.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos. foetus)

(Lived 3' 15")

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Nephritis on part of Mother

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?.....

(Signed) Dudley P. Bonne M. D

19 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
United Ridge Cem	Apr 25 1924
20-UNDERTAKER. John O. Mitchell	ADDRESS 1201 10 Eutaw

N. B.—WRITE PLAINLY. All items must be stated EXACTLY. PHYSICIANS filling this CERTIFICATE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86280

CERTIFICATE OF DEATH.

49 ✓

D 86280

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Saint Agnes Hosp Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mrs. Pauline Hicks

(a) Residence No.... 2010 E. Riggs Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Hicks

6-DATE OF BIRTH (month, day and year) 1901

7-AGE, 23 yrs ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeping house

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Harry Carter

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Lilie Dadds

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) Lillie Carter

(Address) 2010 Riggs Ave

15- APR 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 25 1924

17- I HEREBY CERTIFY, That I attended deceased from April 25 1924 to April 25 1924

that I last saw her alive on April 25 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia due to Lung metastases

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Chorio-Epithelioma

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 3/29/24

Was there an autopsy? No

What test confirmed diagnosis? Path

(Signed) H. W. Harper M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	April 28, 1924
20-UNDERTAKER,	ADDRESS
[illegible]	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. See In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86281

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86281

13

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Altvater

(a) RESIDENCE NO. 2752 Harlem Av. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. L. J. Altvater Jr

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Ellanora A Legg

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr Wm. Altvater
(Address) 2752 Harlem Ave

Dec. 19 ROBERT M. KRAUTER, Burial Permit Clerk

APR 25 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-1924

17

I HEREBY CERTIFY, That I attended deceased from 4-20-, 1924, to 4-24-, 1924,

that I last saw her alive on 4-24-, 1924,

and that death occurred, on the date stated above, at 7 23 A m.

The CAUSE OF DEATH* was as follows:

Pyelitis
acute nephritis
suppression of urine

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. D Parr, M. D.

4/25, 1924 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park cemetery	April 26 1924
20 UNDERTAKER	ADDRESS
James Dignan & Son	1600 S. Paca St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Josephine Barscz.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36282

CERTIFICATE OF DEATH.

90

D 36282

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. East Brooklyn Hights ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine B Barscz

(Residence in Baltimore: No. East Brooklyn Hights St.; 6 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female,	White,	Single,

6-DATE OF BIRTH, December 25th., 1918.
(Month) (Day) (Year)

7-AGE, 6 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer)..... Child,

9-BIRTHPLACE, (State or Country), Baltimore, MD.

PARENTS.

10-NAME OF FATHER, Peter Barscz,

11-BIRTHPLACE OF FATHER (State or Country), Baltimore, MD.

12-MAIDEN NAME OF MOTHER Genevieve Sczepkowski,

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Barscz,

(Address) East Brooklyn Hights, MD.

15-

Filed....., 191..... ROBERT F. KRAUTER, Registrar.

APR 25 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 4 (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/6 1924, to 4/18 1924, that I saw h[illegible] alive on 4 1924, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Unilateral Lobar pneumonia of the left

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. G. Krauter M. D.

4/24, 1924 (Address) 918 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
ST. STANISLAUS CEMETERY	April 26., 1924.
20-UNDERTAKER M. F. Sadowski,	ADDRESS 705 S. Ann St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 86283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86283

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1637 Clarkson ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A Frost

(a) RESIDENCE NO. 1637 Clarkson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Frost

6 DATE OF BIRTH (month, day, and year) Aug 23/850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Marble Setter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Ronas Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Ballet

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Catherine Frost (Address) 1637 Clarkson st

15 Filed APR 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to April 22, 1924, that I last saw h alive on April 22, 1924, and that death occurred, on the date stated above, at 12 45a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. R. Campbell M. D.

April 23 1924 (Address) 1644 Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Apl 26 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4708 Henrietta ave. ST., Lowerville WARD)

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Joseph & Edna E. Kurtz

(a) RESIDENCE No. 4708 Henrietta ave. ST., Lowerville WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 25th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Kurtz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Edna E. Volbrechtsen

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Joseph Kurtz
(Address) 4708 Henrietta ave.

15 APR 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25th, 1924, to April 25th, 1924,

that I last saw him alive on April 25th, 1924,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia - due to breech presentation + prolonged delivery of head.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) A. W. Bacon, M. D.

, 19 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: April 25, 24

20 UNDERTAKER: Fredk Lassahn & Sons — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT. All information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86285

CERTIFICATE OF DEATH.

90 D 86285

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1406 Hollock ST., 15 WARD)

2-FULL NAME Annie M. Stevens

(a) RESIDENCE NO. 1406 Hollock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

If married, widowed, or divorced, HUSBAND of or WIFE of: Widow of James Stevens

6 DATE OF BIRTH (month, day, and year): June 7 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	4	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Vilma Hopkins (Address) 1406 Hollock St.

15 Filed APR 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Apr 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows: Mitral Stenosis

(duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. C. Wade, M. D.

4/25/24 (Coroner) (Address) 1435 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Apr. 25 1924

20 UNDERTAKER: Sam'l D. Stanley ADDRESS 578 N. Gilmor St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

Tyler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86286

CERTIFICATE OF DEATH.

11-002

D 86286

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Gray Tyler

(Residence in Baltimore: No. 2025 McCulloh St. ..... St.; ..... yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 25, 1895
(Month) (Day) (Year)

7-AGE, 28 yrs. 6 mos. 29 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Tailor Maid
(b) General nature of industry, business, or establishment in which employed (or employer), Leonard Hotel

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Chas. N. Gray

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Louisa Tolbston

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian N. Tyler

(Address) 2025 N. McCulloh St

15-
Filed APR 25 1924, 191.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 24, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/17 1924, to 4/24 1924, that I saw h.. alive on 4/24 1924, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Influenza

Ac. Nephritis

(Duration) since 3/17 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) D. McCulloh M. D.

4/24, 1924. (Address) 2130 N

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, Apr. 27, 1924

20-UNDERTAKER, Edward Kennedy ADDRESS 525 Biddle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86287

CERTIFICATE OF DEATH.

X-31

D 86287

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 78 Ridgley St. ward 23 St.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence Wright.

(a) RESIDENCE. No. 78 Ridgley St. ward 23 St.. WARD. 6.

(Usual place of abode) (If nonresident give city or town and State)

* Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Wright

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Adam

9 BIRTHPLACE (city or town) (State or country) Fort Mott S. C.

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Bridget Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Isaac Wright (Address) Metrowinds

15 Filed APR 25 1924 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/19/ 1924, to 4/23/ 1924.

that I last saw him alive on 4/22/ 1924.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T B

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Columbia, S. C

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Hawkins, M. D.

1924 (Address) 912 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Apr 26 1924

20 UNDERTAKER Saml D Hemsley ADDRESS 928 N Gilmor St

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

Earley C Barber

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86288

101-001 D 86288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411-N-pine ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earley Franklin Barber

(a) RESIDENCE NO. 411-N-pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Martha Barber

6 DATE OF BIRTH (month, day, and year) 10-4-64

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Waiter

(c) Name of employer United Coop. Co. Martinsburg W. Va.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER William Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Covington Va.

12 MAIDEN NAME OF MOTHER Harriett Cannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Front Royal, Va.

14 Informant Martha Barber

(Address) 411 N Pine St

15 Filed ROBERT R. KRAETZER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/1924

17 I HEREBY CERTIFY, That I attended deceased from 4/21/1924 to 4/24/1924.

that I last saw him alive on 4/23/1924

and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 808 W Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4/26/24
UNDERTAKER	ADDRESS
R. E. Gross	1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86289

CERTIFICATE OF DEATH.

49 ✓ D 86289

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Roscoe

(a) Residence No. 613 N. Calvert St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day,
65 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), New York.

PARENTS.

10-NAME OF FATHER, Edward Roscoe.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York.

12-MAIDEN NAME OF MOTHER, Ella Hart.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New York.

11- (Informant)

(Address)

15- APR 25 1924 ROBERT P. KRAUTZ Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/22/24

17- I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to April 22, 1924, that I last saw him alive on April 22, 1924, and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma

(Left testicle - general metastasis.)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb. 1924

Was there an autopsy? No.

What test confirmed diagnosis? Pathological Report

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
20-UNDERTAKER, Commissioner of Health.	ADDRESS APR 25 1924

Burial Permit Clerk.

N. B.—WRITE PLAINLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86290

CERTIFICATE OF DEATH.

D 86290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N. Front st ST.; 3 WARD)

REGISTERED NO. C 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Genco

(Residence in Baltimore: No. 14 N. Front st St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Marr

6-DATE OF BIRTH, March 29th (Month) (Day), 1891 (Year)

7-AGE, 33 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 004

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Joseph Genco

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rosa Incotro

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Genco

(Address) 325 N. High st

15-

Filed APR 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 24 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 9 1924, to Apr. 24 1924, that I saw him alive on Apr. 23 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. Testa M. D.

, 191... (Address) 710 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Cross

DATE OF BURIAL. April 29th, 1924

UNDERTAKER P. J. Pipelow

ADDRESS 1800 E 32nd N.

N. B.—Every item of information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86291

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D 86291

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hamilton ave ST., 2 WARD)

2-FULL NAME Loretta Elizabeth Goldsborough

(a) RESIDENCE No. Hamilton ave, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 20-1906

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
17	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenog.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: W. S. F. S.

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Lloyd M. Goldsborough

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Clara B. Knopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Lloyd M. Goldsborough

(Address): Hamilton ave

15 Filed APR 25 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 19 24

17 I HEREBY CERTIFY, That I attended deceased from 4/13/24, 19.., to 4/24/24, 19.., that I last saw her alive on 4/24/24, 19.., and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) yrs. 0 mos. 12 ds.

CONTRIBUTORY (Secondary) Acute Condroc Dilatation

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Albert L. Levy. M. D.

4/25/24 (Address) 1235 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood

DATE OF BURIAL: April 27, 19 24

20 UNDERTAKER: Pinkler & Pinkler

ADDRESS: 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86292

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 86292

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 410 S Fouthill av St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Baby Meile

(Residence in Baltimore: No. 410 S Fouthill av St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. April (Month) 21 (Day) 1924 (Year)

7-AGE. .....yrs. .....mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. George H. Meile

11-BIRTHPLACE OF FATHER, (State or Country). Balto City

12-MAIDEN NAME OF MOTHER. Florence M Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Lula Meile

(Address). 410 S Fouthill ave

15- Robert F. [illegible], Registrar.

Filed..... 192.....

PR 25 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 24 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Hes death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Congestion
Brain (Possibly Lues)

.....(Duration).....yrs.....mos. 3 ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) James M Fenton M. D.
(Coroner.)

April 24 1924 (Address) 760 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Int. Olivet	Apr. 25 1924
20-UNDERTAKER.	ADDRESS.
George L. Schwabe	101 Fremont Ave.

P. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If under one year state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 802 Bevans St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Charles Smith

(a) Residence No.... 802 Bevans St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(wife)~~ WIFE of Hetta Smith

6-DATE OF BIRTH (month, day and year) Feb 13 1872

7-AGE. 52 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

14- (Informant)..... Hetta Smith

(Address)..... 802 Bevans St

15- Filed ..... 192.....

Robert P. Harrison,
Registrar.

~~Burial Permit Clerk.~~

APR 25 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 24 24

17- I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1924, to Apr 24, 1924, that I last saw h.... alive on Apr. 23, 1924, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(Duration) ? yrs. 4 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis*.....

(Signed) D. Harrison M. D.

4/25, 1924 (Address) 1400 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Ct	April 27, 1924
20-UNDERTAKER,	ADDRESS
S. Lee Brown & Son	1018 W Mont'y

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86294

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Summie Kemmer

(a) Residence No. 533 Barre St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. Yrs. 38 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife

(b) General nature of industry, business, or establishment in which employed (or employer). 070

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country). Calvert Co. Maryland.

PARENTS.

10-NAME OF FATHER. William Kemmer

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Calvert Co. Maryland

12-MAIDEN NAME OF MOTHER. Eliza Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Calvert Co. Maryland

14- (Informant) Hospital Record

(Address) Baltimore Hospitals

15- Robert P. Harrison, Registrar.

Filed ..... 192.....

APR 25 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/23/24

17- I HEREBY CERTIFY, That I attended deceased from March 26, 1924 to April 23, 1924

that I last saw her alive on April 23, 19 24.

and that death occurred, on the date stated above, at 6-20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Generalized Metastasis)

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Over a yr ago

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological findings

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Chesapeake Beach Calvert Co Md — DATE OF BURIAL, April 26, 1924

20-UNDERTAKER, J. L. Brown & Son — ADDRESS 108 W Monta

Route W. Bal. & E R R to Chesapeake Beach Calvert Co Md

N. B.—WHITE CERTIFICATES. Information should be carefully supplied. AGE should be stated EXACTLY. PERSONAL AND STATISTICAL PARTICULARS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important in plain terms, so that it may be properly classified. Read instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Louis Larsen)

D 86295

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09 86295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lars Larsen

(a) RESIDENCE NO. 1229 Cuba ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Wid

5a If married, widowed, or divorced
(HUSBAND) of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	61	—	—	—

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steamfitter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Norway
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Louis Schwanke
(Address) 1225 Richardson St

15 Rec'd APR 25 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.)
find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

(Signed) [illegible] (Coroner.), M. D.

April 25, 1924 (Address) 1654 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) not given
At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lutheran Evangelical Cem	April 26 1924
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of certificate. TION is very important. See instructions on back of

Cor.—1-12-23—M&T—100 Bks.

D 86296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86296

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cross Country Building ST., 18 WARD) 24001 Baltimore

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Kiel

(a) RESIDENCE NO. 747 Bennett ST., 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Kiel

6 DATE OF BIRTH (month, day, and year) Mar 16 61

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	63	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER C. F. Kiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Margaret A. Brundige

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant John A. Kiel
(Address) 747 Bennett Place

15 Robert P. Harrison, Registrar
APR 25 1924 192
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. H. Thomas M. D.
(Coroner.)
April 23 1924 (Address) 763 Robinson

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral.	4/26 192
20 UNDERTAKER H. C. Brauneagle	ADDRESS 517 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of disease must be given. Indefinite terms, such as "Heart Disease," "Cancer," "Tumor," "Stroke," "Kidney Trouble," "Dropsy," "Fever," "Debility," "Old Age," "Infection," "Septicemia," "Pneumonia," "Meningitis," "Hemorrhage," "Convulsions," "Uremia," "Asthenia," "Exhaustion," "Paralysis," "Abscess," "Gangrene," "Ulcer," "Blood Poisoning," "Malignant Disease," "Carcinoma," "Sarcoma," "Tuberculosis," "Pulmonary Tuberculosis," "Lung Trouble," "Consumption," "Pleurisy," "Bronchitis," "Asthma," "Hernia," "Appendicitis," "Peritonitis," "Intestinal Obstruction," "Liver Trouble," "Jaundice," "Hepatitis," "Cirrhosis," "Gastritis," "Enteritis," "Colitis," "Nephritis," "Bright's Disease," "Albuminuria," "Cystitis," "Prostatitis," "Urethritis," "Metritis," "Salpingitis," "Ovaritis," "Abortion," "Childbirth," "Puerperal Septicemia," "Puerperal Infection," "Puerperal Convulsions," "Puerperal Hemorrhage," "Puerperal Fever," "Puerperal Abscess," "Puerperal Gangrene," "Puerperal Ulcer," "Puerperal Blood Poisoning," "Puerperal Malignant Disease," "Puerperal Carcinoma," "Puerperal Sarcoma," "Puerperal Tuberculosis," "Puerperal Pulmonary Tuberculosis," "Puerperal Lung Trouble," "Puerperal Consumption," "Puerperal Pleurisy," "Puerperal Bronchitis," "Puerperal Asthma," "Puerperal Hernia," "Puerperal Appendicitis," "Puerperal Peritonitis," "Puerperal Intestinal Obstruction," "Puerperal Liver Trouble," "Puerperal Jaundice," "Puerperal Hepatitis," "Puerperal Cirrhosis," "Puerperal Gastritis," "Puerperal Enteritis," "Puerperal Colitis," "Puerperal Nephritis," "Puerperal Bright's Disease," "Puerperal Albuminuria," "Puerperal Cystitis," "Puerperal Prostatitis," "Puerperal Urethritis," "Puerperal Metritis," "Puerperal Salpingitis," "Puerperal Ovaritis," "Puerperal Abortion," "Puerperal

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86297

CERTIFICATE OF DEATH.

49

D 86297

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Longwood ST.: 20 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin F. Marr

(Residence in Baltimore: No. 518 Longwood St.: 70 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	

6-DATE OF BIRTH. Sept (Month) 23 (Day), 1853 (Year)

7-AGE. 70 yrs. 7 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 062

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. F. Warfield

(Address) 518 S. Longwood St.

15-

Filed APR 25 1924 Robert P. Harrison, Registrar.

Central Record Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1924, to April 25 1924, that I saw h— alive on April 25 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Metastasis to Spine

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Howard W. Jones M. D.

April 25, 1924 (Address) 1 E. Read St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. 4/26, 1924

20-UNDERTAKER Robert Boorkman

ADDRESS Calhoun & Hollins Sts

...—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86298

D 86298

CERTIFICATE OF DEATH.

REGISTERED NO. 188-506

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST., WARD)

2-FULL NAME Grace H. Thompson

(a) RESIDENCE No. 1814 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jasper Thompson

6 DATE OF BIRTH (month, day, and year) Oct 11 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Whittaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary McCreight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ella Pendleton (Address) 303 Wilson St

15 Filed . 192 Registrar Robert P. [illegible]

APR 25 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident

Comp Fract. Internal Hemorrhage.

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. 15 ds.

(Signed) Geo Clinton Rhodes, M. D.

(Coroner)

4/25/24 192 (Address) 175 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL 4/26 24

20 UNDERTAKER Geo E Tilley ADDRESS Fulton & Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

170371 D 86299

CERTIFICATE OF DEATH.

X 135 D 86299

1-PLACE OF DEATH Johns Hopkins Hosp

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Lee Ander Trowell

(a) RESIDENCE NO. Weston, W. Va. ST., ... WARD Weston W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lee Trowell

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Farmer and

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer ..... —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John L. Troxell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant ..... Records

(Address) Johns Hopkins Hosp

15 Filed R 26 1924 Robert P. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1924, to April 25, 1924, that I last saw h.. alive on April 25, 1924, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary embolism.

(duration) 0 yrs. 0 mos. 30 min. 0 ds.

18 Where was disease contracted if not at place of death? West Virginia.

Did an operation precede death? yes Date of March 28

Was there an autopsy? yes

What test confirmed diagnosis? autopsy.

(Signed) Eugene C. Eliot, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Weston W. Va.

DATE OF BURIAL 4/28/24 19

20 UNDERTAKER H. E. Hughes & Son

ADDRESS N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D 86300

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3821 Hickory Ave ST., 13 WARD)

2-FULL NAME Clara M Hollingshead

(a) RESIDENCE NO. 3821 Hickory Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 9, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME Carroll A Hollingshead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER M Catherine Mitchelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Mrs M Catherine Hollingshead

(Address) 3821 Hickory Ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk.

R 26124

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1924

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1924, to April 24, 1924, that I last saw h e alive on April 24, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Mackin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel	Apr 26 19 24

20 UNDERTAKER A S Marshall ADDRESS 3539 Fall Road

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S should be carefully supplied. Exact statement of OCCUPATION may be properly classified. AGE should be stated EXACTLY. PHYSICIAN'S should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 86301

1-PLACE OF DEATH Bay View Hospital 26 38 Registered No.....

City of BALTIMORE: (No. 700 Old Second Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Bigham

(a) Residence No. 700 Old Second Ave, St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 18 1894

7-AGE. 30 yrs. 1 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Factory Worker

(b) General nature of Industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Bay View Hospital

(Address)

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

APR 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24 1924

17- I HEREBY CERTIFY, That I attended deceased from July 8, 1923 to April 24 1924, that I last saw h.. alive on April 24 1924 and that death occurred, on the date stated above, at 11 00 P m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Lues Unknown

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith M. D.

4/25/1924 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. 4/28/ 1924

20-UNDERTAKER Walter Davis ADDRESS 3307 Pinkney Av.

8.—WHITE CARD. should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86302 D 86302

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Prod'y Entaw sl - ST., 7 WARD)

2-FULL NAME John F. Hennick

(a) RESIDENCE (Usual place of abode) NO 507 N Dukeman ST., WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced ~~(write the word)~~: married

5a If married, widowed, or divorced
~~(or) WIFE of~~ HUSBAND of: Lena Hennick

6 DATE OF BIRTH (month, day, and year) Sept 15-1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Foreman 086
(b) General nature of industry, business, or establishment in which employed (or employer): Southeastern Express Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James F. Hennick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Catherine Steibler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Lena Hennick
(Address) 507 N Dukeman Ave

APR 26 1924

Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart (duration) Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know (duration) yrs. mos. ds.

(Signed) H H Fenby M. D. (Coroner.)

4-25-, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Apr 28 1924

20 UNDERTAKER: Mrs C. Miller — ADDRESS 2334 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of DISEASE is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86303

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86303

99-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1605 Harman alley St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary M. Upperman

(a) Residence No. 1605 Hotman alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 4-1923.

7-AGE, ...yrs. 4 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None, 000

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Edgar Upperman,

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Nellie Jones.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland.

14-

(Informant) Mr. Edgar Upperman

(Address) 1605 Hotmans alley

APR 26 1924 Robert P. Harrison, 19.....

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 25-1924

17- I HEREBY CERTIFY, That I attended deceased from April 22 19 24 to April 25 19 24

that I last saw h.. alive on... April 25 19 24

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration).....yrs.....mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. K. Campbell, M. D.

Apr 26 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem — DATE OF BURIAL, Apr 28 1924

20-UNDERTAKER, Edw. F. Cowan & Son, Per E. F. Cowan — ADDRESS 901 Holliday St

Filed.

Instructions on back of certificates.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is very important. See In plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D 86304 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86304

CERTIFICATE OF DEATH. 83

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 21 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Burns.

(a) RESIDENCE NO. 19 N Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Married.

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sallie Orndorff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Johns Hopkins Hospital

15 Dec 19 Robert P. Harrison, Registrar
Burial Permit Clerk

APR 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1924, to April 24, 1924, that I last saw h. alive on ~~April 24~~ 4/24, 1924, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Orbital Abscess with
possible Cavernous Sinus
Thrombosis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Sinus thrombosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 4/21/24

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Winfield M. Fiser, M. D.

(Address) 3 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 28 1924
20 UNDERTAKER	ADDRESS
John F. Cowan & Son	Gordon Ave
Per F. J. Cowan	

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Physician, Coroner or Undertaker should be carefully supplied. AGE mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

D-86305

HEALTH DEPARTMENT--CITY OF BALTIMORE

(W)-86305

CERTIFICATE OF DEATH

161-001

1 PLACE OF DEATH

Registered No. C .....

CITY OF BALTIMORE (No. 1029 Bare St. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosalie C. Bradley

(Residence in Baltimore: No. 1029 Bare St.; yrs. 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): S

6-DATE OF BIRTH: March 22nd, 1924 (Month) (Day) (Year)

7-AGE: ..... yrs. 1 mos. 3 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 00

9-BIRTHPLACE (State or country): Baltimore

PARENTS

10-NAME OF FATHER: Thomas Bradley

11-BIRTHPLACE OF FATHER (State or country): Pa.

12-MAIDEN NAME OF MOTHER: Rosie Kraff.

13-BIRTHPLACE OF MOTHER (State or country): Baltimore, Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Thomas Bradley

(Address) 1029 Bare St

APR 26 1924

Filed 191

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 25th, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22, 1924, to April 25th 1924, that I saw her alive on April 23rd 1924, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Premature birth (7 mos)

(Cause inflammatory rheumatism in mother)

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Inflamatory rheumatism

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Jennie R Brown M. D.

April 25th, 1924 (Address) 1225 S Ethan St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Pk Cemetery — DATE OF BURIAL: 4-26 1924

20-UNDERTAKER: Geo Leimbacher Son — ADDRESS: 647 N Pratt St

Attest.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86306 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86306

CERTIFICATE OF DEATH.

No 74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 335 S. East Ave St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Bernhard Ochsenkiel

(a) Residence No. 335 S. East Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single~~ Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Regina Ochsenkiel

6-DATE OF BIRTH (month, day and year) July 8/1850

7-AGE, 73 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Retired Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER August Ochsenkiel

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Germany

14- (Informant) August Ochsenkiel

(Address) 335 S. East Ave

APR 26 1924 Robert P. Harrison, Registrar.

Dr Jay Groff Lombard St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 23 24

17- I HEREBY CERTIFY, That I attended deceased from April 18, 19 24 to 4/23/24, 19 24, that I last saw h... alive on 4/23/24, 19....., and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

..... (Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) Bernard J. Turn, M. D.

4/25, 19 24 (Address) 410 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL, Apr 26, 19 24

20-UNDERTAKER. William Cook ADDRESS 502 E Balto

Am.

If DEATH occurred in a hospital or institution, or while person was in transit, or elsewhere than at residence, see that the RESIDENCE is also given. Exact statement of OCCUPATION is very important. Fill in all items carefully and correctly. AGE should be carefully supplied. If exact date of birth cannot be obtained, the AGE should be stated as accurately as possible. Write plainly in ink. Use only standard abbreviations. Do not use ditto marks. Make no erasures. Write in plain terms, so that it may be properly classified. Refer to instructions on back of certificates.

Spec– 12-23-21—E.B.&S.—400 Bks.

D 86307 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 857 Woodward St. 21 Ward)

Registered No. 144

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Davis

(a) Residence No. 857 Woodward St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. M. Davis

6-DATE OF BIRTH (month, day and year): July 19, 1892

7-AGE. 31 yrs. 9 mos. 4 ds. If LESS than 1 day, hrs. or. mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Salto Md

PARENTS.

10-NAME OF FATHER: Conrad Matthews

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Salto Md

12-MAIDEN NAME OF MOTHER: Christina Carter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant): C. M. Davis

(Address): 857 Woodward

APR 26 1924

15-Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-24-24

17-I HEREBY CERTIFY, That I attended deceased from Apr 23. 24 to Apr 23 24

that I last saw h. alive on Apr. 23 24

and that death occurred, on the date stated above, at 5.15 P. M.

The CAUSE OF DEATH* was as follows:

Adherent Placenta

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Shock

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross

(Signed) John G. Schwensberg M.D.

(Address) 1 Mawlawn St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL, April 26, 1924

20-UNDERTAKER: Wm Coale. — ADDRESS: 502 E Main

Name.

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Cor.—1-12-25—M&T—100 Bks.

D 86308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86308

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Whithoby

(a) RESIDENCE NO. 1735 McCubbin St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Whithoby

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50 to 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Don Whithoby

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Bessie Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Florence Whithoby
(Address) 1735 McCubbin St.

15 Filed ..... 192 Robert P. Harrison, Registrar

PR 2 6 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage rt. ventricle (Cerebral)
(Assaulted by Wm. Jacobitsky)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syphillitic Aortitis-Arteriosclerosis (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Weller, M. D.
(Coroner.)

Apr 24 192 (Address) 5pi E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL April 26 1924

20 UNDERTAKER Edward Bryson

ADDRESS 431 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.—400 Blks.

D 86309

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 D 86309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Francis Keyser.

(a) Residence No. 709 S. Bond Street St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 81 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wrk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11-

(Informant)

(Address) Municipal Hosp. Records

15-

Filed..... Robert P. Harrison Registrar.

APR 26 1924

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/24/24.

17- I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1923, to April 24, 1924, that I last saw her alive on April 24, 1924, and that death occurred, on the date stated above, at 3-45 P. m.

The CAUSE OF DEATH* was as follows:

Angina - pectris - Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Varicose ulcers Leg

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical findings.

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cemetery	April 26th 1924
20-UNDERTAKER,	ADDRESS
J. Lignan & Son	1008 S. Paca St.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86310

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 Montebello Terrace ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Diehl

(a) RESIDENCE NO. 124 Montebello Terrace ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? 67 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles A. Diehl

6 DATE OF BIRTH (month, day, and year) Aug. 10 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Scharf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Anna Valentine

(Address) 124 Montebello Terrace

15 APR 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1924 to Apr 25 1924, that I last saw h[illegible]live on April 24 1924, and that death occurred, on the date stated above, at 10:25 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia : Chronic Interstitial [redacted] Nephritis

(duration) yrs. ... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Urine

(Signed) Carl Smith, M. D.

4/25, 1924 (Address) 24 W. Mt. Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Apr. 28, 1924

20 UNDERTAKER Henry Hoard Sons — ADDRESS 1201 E Eager St

B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86311

CERTIFICATE OF DEATH.

-162

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2943 Westwood Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Henry Benner

(a) Residence No. 2943 Westwood Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 25-1924

7-AGE, ... yrs. ... mos. 1 dls.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None old

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Emil L. Benner

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country), Md

12-MAIDEN NAME OF MOTHER, Matilda Baer

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country), Md

11- (Informant) Emil L. Benner

(Address) 2943 Westwood Ave

PR 26 1924

12- 19 ... 13- Robert P. Harrison, 19 ... Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26-1924

17- I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to April 26, 1924,

that I last saw him alive on ..... 19 ....,

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Prolonged Labor —

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edw. Gambrill M. D.

4/26, 1924 (Address) 517 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemt	April 27th 1924
20-UNDERTAKER, Peter Dove	ADDRESS 1923 W. Lafayette Ave

Exact statement of OCCUPATION is very important. ... should be carefully supplied. AGE should be stated exactly in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86312

HEALTH DEPARTMENT—CITY OF BALTIMORE

86312

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1115 W. Cross St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Maynard Crouse Jr.

(a) Residence No. 1115 W. Cross St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 5th 1909

7-AGE.	If less than 1 day,
14 yrs. 11 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Oscar M. Crouse Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Katherine Schoen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

11- (Informant) Oscar M. Crouse Jr.
(Address) 1115 W. Cross St.

15- Rec'd APR 26 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 24 1924

17- I HEREBY CERTIFY, That I attended deceased from March 8 1924 to April 24 1924
that I last saw h.. alive on April 23 1924
and that death occurred, on the date stated above, at 5-30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Med

(Signed) Edw Grandstaff M. D.

4/26. 1924 (Address) 57 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	April 28. 1924
20-UNDERTAKER.	ADDRESS
Jos Joerdens & Son	2178 Pac

Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 86313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86313

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Robinson ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Tieman

(a) RESIDENCE NO. 502 N.Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie B. Stallings

6 DATE OF BIRTH (month, day, and year) Oct 4/1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6 20		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Tieman

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mamie B. (Stallongs) Tieman
(Address) 502 N. Robinson St

15 Filed Robert P. Harrison, Registrar

PR 26 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1< hr

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) E. K. Waller, M. D.
(Coroner.)

Apr 25/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem DATE OF BURIAL Apr 28 1924

20 UNDERTAKER John Ellicot ADDRESS 208 Orleans

REGISTRATION should be carefully supervised. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86314

CERTIFICATE OF DEATH.

90 D 86314

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Ann St.: 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otis Johnson.

(a) RESIDENCE. No. 223 Ann St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Johnson.

6 DATE OF BIRTH (month, day, and year) November 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carroll H. Johnson

(Address) Chase Balto. Md.

15 Filed Apr 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1924, to Apr 24, 1924, that I last saw h.. alive on Apr 23, 1924, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W. Watts M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	April 26 1924
20 UNDERTAKER John W Henderson	ADDRESS 1502 E. Monument

I.—WRITE PLAINLY. Full name should be stated EXACTLY. Residence and mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86315 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier # 2 ST., 4 WARD)

REGISTERED NO. 1820

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin J. O'Toole

(a) RESIDENCE No. 55 Steuart ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Judith F. Toole

6 DATE OF BIRTH (month, day, and year) Dec 5 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Accountant 004
(c) Name of employer

9 BIRTHPLACE (city or town) Prescott
(State or country) Wisconsin

PARENTS

10 NAME OF FATHER Wm J. O'Toole

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Anna E Towey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant William H. O'Toole
(Address) Lakeside Wisconsin

15 Filed APR 25 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. E. Blake, M. D.
(Coroner.)
Apr 24 192 (Address) 1715 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul Mines, via B&R	Apl 26 192 6
20 UNDERTAKER John F Denny	ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86316

D 86316

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 16 Rosedale Ave. Hamilton 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Nedora Rehling

(a) Residence No. 16 Rosedale Ave. Hamilton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of J. Henry Rehling

6-DATE OF BIRTH (month, day and year) Aug. 3 1885

7-AGE.	If LESS than 1 day.
38 yrs. 8 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country).

PARENTS

10-NAME OF FATHER. Daniel W. Duvall

11-BIRTHPLACE OF FATHER (city or town)..... Md.
(State or Country).

12-MAIDEN NAME OF MOTHER. Amelia J. Fleming

13-BIRTHPLACE OF MOTHER (city or town)..... Md.
(State or Country).

14-

(Informant)..... Mrs. Duvall (sister)

(Address)..... 16 Rosedale Ave.

15-

Filed..... Robert P. Harrison Registrar.

PR 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr 24-24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1918, to Apr 24 1924, that I last saw h.r alive on Apr 23 1924, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam.

(Signed) M Bernard Hood M. D

Apr 25. 1924 (Address) 626 N. Gilmor St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	4/26 1924
20-UNDERTAKER.	ADDRESS
I. Few McCully	130 E. Fort Ave.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86317

CERTIFICATE OF DEATH.

75-91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Waters

(a) RESIDENCE NO. 1817 Vine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15 Robert P. Harrison, Registrar

APR 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-31, 1923, to 4-23, 1924,

that I last saw him alive on 4-23, 1924,

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Right Hemiplegia (Hemorrhage)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin

(Signed) Claude G. Dunn, M. D.

4-23 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	APR 26 1924

20 UNDERTAKER	ADDRESS
Commissioner Health.	

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1508 Presstman St WARD) 15

REGISTERED NO. 74-D 86318

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Nelson

(a) RESIDENCE. NO. 1508 Presstman ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) — — 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs Billips (Address) 1508 Presstman St

15 Filed ....., 19 Robert P. Harrison Registrar

APR 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/ 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1924 to April 24 1924, that I last saw h[illegible] alive on 4/23/24, and that death occurred, on the date stated above, at 1 4 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. 2 weeks.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W Boyles, M. D.

, 19 (Address) 1618 Calla

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemtery	4/26/ 1924
20 UNDERTAKER	ADDRESS
Mrs James N. Dennis	1303 Presstman St

N. B.—WRITE PLAINLY, WITH INK. ALL ITEMS should be stated EXACTLY. Any abbreviation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86319 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Gracland Pk) REGISTERED NO. 16200

CITY OF BALTIMORE: (No. Railway ave & Longplace St., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Maxwell

(a) RESIDENCE. No. Railway & Longplace ave St., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 24-1924

7 AGE: Years — Months — Days 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS'

10 NAME OF FATHER Theodore Maxwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Eleanor Ey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Theodore Maxwell
(Address) Railway & Longplace ave

15 Filed ..... 19 ..... Robert F. ... Registrar

APR 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to April 25, 1924, that I last saw h.. alive on April 25, 1924, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY —
(Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. W. Rice, M. D.

4/25 1924 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL 4/26 1924

20 UNDERTAKER: Philip Henrig, Orleans — ADDRESS 2016

N. B.—WRITE PLAINLY. ... should be carefully supplied, AGE should be stated EXACTLY. ... mation should be carefully supplied, AGE should be stated EXACTLY. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86320

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 N. Regester St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August W. Lessner

(a) Residence No. 1610 N. Regester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 23/11

7-AGE. 12 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Wm M. Lessner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Elizabeth M. Westerhoff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Mrs M. Lessner
(Address) 1610 N. Regester

15- Filed APR 26 1924 Robert P. Harrison, Registrar.
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 23/24

17- I HEREBY CERTIFY, That I attended deceased from Feb. 4 1924 to April 23 1924, that I last saw him alive on April 23 1924 and that death occurred, on the date stated above, at 10-30 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) An intercurrent pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J Watson, M. D

April 26, 1924 (Address) 2128 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	4/28 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Orleans

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Cor.—1-12-23—M&T—100 Bks.

D 86321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86321

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Argyle ST., 17 WARD)

2-FULL NAME Selina Evans.

(a) RESIDENCE NO. 1001 Argyle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Evans

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) House Wife
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Frances Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Isaac Evans (Address) 1101 Argyle ave

15 Filed APR 26 1924 Hubert F. Harris, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Endocarditis (duration) 2 yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. C. Leab M. D.
(Coroner.)
1924 (Address) 1113 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL April 27 1924

20 UNDERTAKER Wm R.G. Elliott ADDRESS 1722 Eastland ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.
TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86322

CERTIFICATE OF DEATH.

3 | D 86322

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 111-20 St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgiana Barrett

(a) RESIDENCE NO. 111-20 St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem'l	C.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Barrett

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George Barrett

(Address) 111 N. 20th St.

15 Filed APR 26 1924, 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

(Signed) G. C. Slade, M. D.

(Coroner.)

(Address) 423 E. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL April 26 1924

20 UNDERTAKER Mrs R. C. Elliott ADDRESS 172 Eastland ave

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be understood by a clerk of average knowledge. ATTENTION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86323

CERTIFICATE OF DEATH.

46 D 86323

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 104 E. Biddle ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Louise Detrick

(a) RESIDENCE No. 104 E Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-20-1869

7 AGE — Years: 55 — Months: 2 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

~~Butcher 11/20/24~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Louis Frederick Detrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co Md

12 MAIDEN NAME OF MOTHER: Kate Munshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: W. H. Detrick

(Address): 104 E Biddle

15 Filed APR 26 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1924

17 I HEREBY CERTIFY, That I attended deceased from January, 1924, to April, 1924, that I last saw h[illegible] alive on April 25 1924, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Metastatic Adenocarcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma peritonei

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Yes Date of May 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Warren Buckler, M. D.

19 W (Address) 606 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 4-28, 1924

20 UNDERTAKER: Henry W Justice Eq Love Co — ADDRESS: McCulloh & Orchard

APR 26 1924

GE should be stated EXACTLY. Literal
hat it may be properly classified. Exact statement of O PA-
ns on back of certificates.

. 8.—WRITE PLAINLY with pen or ink. Information should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86324

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 2009 Woodbery Ave Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Russell Leroy Jackson

(a) Residence No. 2009 Woodbery Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 10 1920

7-AGE, 3 yrs. 6 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work — — —

(b) General nature of industry, business, or establishment in which employed (or employer) — — —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Horace E Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary James

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) H. E. Jackson

(Address) 2009 Woodbery Ave

15- Filed ....., 192.. Robert P. ..... Registrar.

APR 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26. 24

17- I HEREBY CERTIFY, That I attended deceased from April 24th 24, 19.., to April 26th 24, 19.., that I last saw h.. alive on April 25th 24, 19.., and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

.....(Duration).....yrs.....mos. 1½ ds.

CONTRIBUTORY None
(Secondary)

.....(Duration).....yrs.....mos. 1½ ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.

April, 19 24 (Address) 1 W Mulberry St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Balto | DATE OF BURIAL, April 27 19 24

20-UNDERTAKER CHENOWETH & SON, | ADDRESS 3617 CHESTNUT AVE

Exact statement of OCCUPATION is very important. If deceased was housewife, specify "housewife." If laborer, specify whether "laborer" or "day laborer." If clerk, specify "clerk in store," "office clerk," etc. If child, specify "son of" or "daughter of." If unemployed, specify "unemployed." If retired, specify "retired." If student, specify "student." If none, specify "none." If unknown, specify "unknown." If deceased was married, specify "married." If widowed, specify "widowed." If divorced, specify "divorced." If single, specify "single." If deceased was a minor, specify "minor." If deceased was a child, specify "child." If deceased was a baby, specify "baby." If deceased was a newborn, specify "newborn." If deceased was a stillborn, specify "stillborn." If deceased was a miscarriage, specify "miscarriage." If deceased was a abortion, specify "abortion." If deceased was a ectopic pregnancy, specify "ectopic pregnancy." If deceased was a molar pregnancy, specify "molar pregnancy." If deceased was a hydatidiform mole, specify "hydatidiform mole." If deceased was a choriocarcinoma, specify "choriocarcinoma." If deceased was a teratoma, specify "teratoma." If deceased was a dermoid cyst, specify "dermoid cyst." If deceased was a ovarian cyst, specify "ovarian cyst." If deceased was a uterine fibroid, specify "uterine fibroid." If deceased was a endometriosis, specify "endometriosis." If deceased was a adenomyosis, specify "adenomyosis." If deceased was a leiomyoma, specify "leiomyoma." If deceased was a leiomyosarcoma, specify "leiomyosarcoma." If deceased was a endometrial stromal sarcoma, specify "endometrial stromal sarcoma." If deceased was a mixed mesodermal tumor, specify "mixed mesodermal tumor." If deceased was a carcinosarcoma, specify "carcinosarcoma." If deceased was a adenocarcinoma, specify "adenocarcinoma." If deceased was a squamous cell carcinoma, specify "squamous cell carcinoma." If deceased was a transitional cell carcinoma, specify "transitional cell carcinoma." If deceased was a clear cell carcinoma, specify "clear cell carcinoma." If deceased was a serous carcinoma, specify "serous carcinoma." If deceased was a mucinous carcinoma, specify "mucinous carcinoma." If deceased was a endometrioid carcinoma, specify "endometrioid carcinoma." If deceased was a undifferentiated carcinoma, specify "undifferentiated carcinoma." If deceased was a small cell carcinoma, specify "small cell carcinoma." If deceased was a large cell carcinoma, specify "large cell carcinoma." If deceased was a neuroendocrine carcinoma, specify "neuroendocrine carcinoma." If deceased was a carcinoid tumor, specify "carcinoid tumor." If deceased was a atypical carcinoid tumor, specify "atypical carcinoid tumor." If deceased was a typical carcinoid tumor, specify "typical carcinoid tumor." If deceased was a large cell neuroendocrine carcinoma, specify "large cell neuroendocrine carcinoma." If deceased was a small cell neuroendocrine carcinoma, specify "small cell neuroendocrine carcinoma." If deceased was a combined small cell carcinoma, specify "combined small cell carcinoma." If deceased was a mixed small cell carcinoma, specify "mixed small cell carcinoma." If deceased was a pure small cell carcinoma, specify "pure small cell carcinoma." If deceased was a small cell carcinoma with other components, specify "small cell carcinoma with other components." If deceased was a small cell carcinoma with squamous cell carcinoma, specify "small cell carcinoma with squamous cell carcinoma." If deceased was a small cell carcinoma with adenocarcinoma, specify "small cell carcinoma with adenocarcinoma." If deceased was a small cell carcinoma with large cell carcinoma, specify "small cell carcinoma with large cell carcinoma." If deceased was a small cell carcinoma with neuroendocrine carcinoma, specify "small cell carcinoma with neuroendocrine carcinoma." If deceased was a small cell carcinoma with carcinoid tumor, specify "small cell carcinoma with carcinoid tumor." If deceased was a small cell carcinoma with atypical carcinoid tumor, specify "small cell carcinoma with atypical carcinoid tumor." If deceased was a small cell carcinoma with typical carcinoid tumor, specify "small cell carcinoma with typical carcinoid tumor." If deceased was a small cell carcinoma with large cell neuroendocrine carcinoma, specify "small cell carcinoma with large cell neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell neuroendocrine carcinoma, specify "small cell carcinoma with small cell neuroendocrine carcinoma." If deceased was a small cell carcinoma with combined small cell carcinoma, specify "small cell carcinoma with combined small cell carcinoma." If deceased was a small cell carcinoma with mixed small cell carcinoma, specify "small cell carcinoma with mixed small cell carcinoma." If deceased was a small cell carcinoma with pure small cell carcinoma, specify "small cell carcinoma with pure small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with other components, specify "small cell carcinoma with small cell carcinoma with other components." If deceased was a small cell carcinoma with small cell carcinoma with squamous cell carcinoma, specify "small cell carcinoma with small cell carcinoma with squamous cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with adenocarcinoma, specify "small cell carcinoma with small cell carcinoma with adenocarcinoma." If deceased was a small cell carcinoma with small cell carcinoma with large cell carcinoma, specify "small cell carcinoma with small cell carcinoma with large cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with neuroendocrine carcinoma, specify "small cell carcinoma with small cell carcinoma with neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with carcinoid tumor, specify "small cell carcinoma with small cell carcinoma with carcinoid tumor." If deceased was a small cell carcinoma with small cell carcinoma with atypical carcinoid tumor, specify "small cell carcinoma with small cell carcinoma with atypical carcinoid tumor." If deceased was a small cell carcinoma with small cell carcinoma with typical carcinoid tumor, specify "small cell carcinoma with small cell carcinoma with typical carcinoid tumor." If deceased was a small cell carcinoma with small cell carcinoma with large cell neuroendocrine carcinoma, specify "small cell carcinoma with small cell carcinoma with large cell neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell neuroendocrine carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with combined small cell carcinoma, specify "small cell carcinoma with small cell carcinoma with combined small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with mixed small cell carcinoma, specify "small cell carcinoma with small cell carcinoma with mixed small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with pure small cell carcinoma, specify "small cell carcinoma with small cell carcinoma with pure small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with other components, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with other components." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with squamous cell carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with squamous cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with adenocarcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with adenocarcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with large cell carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with large cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with neuroendocrine carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with carcinoid tumor, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with carcinoid tumor." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with atypical carcinoid tumor, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with atypical carcinoid tumor." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with typical carcinoid tumor, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with typical carcinoid tumor." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with large cell neuroendocrine carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with large cell neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell neuroendocrine carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell neuroendocrine carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with combined small cell carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with combined small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with mixed small cell carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with mixed small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with pure small cell carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with pure small cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell carcinoma with other components, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell carcinoma with other components." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell carcinoma with squamous cell carcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell carcinoma with squamous cell carcinoma." If deceased was a small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell carcinoma with adenocarcinoma, specify "small cell carcinoma with small cell carcinoma with small cell carcinoma with small cell carcinoma with adenocarcinoma." 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Spec.—1-10-2i—M&T—1500 Bks.

D 86325

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D 86325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 Elgin Ave. ST., 15 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Duke Wathen

(a) RESIDENCE NO. 3412 Elgin Ave. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
Lottie V.Wathen

6 DATE OF BIRTH (month, day, and year) July 1.1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship-Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St.Mary's Co. Maryland

PARENTS

10 NAME OF FATHER Robert H.Wathen

11 BIRTHPLACE OF FATHER (city or town) (State or country) St.Mary's Co. Md

12 MAIDEN NAME OF MOTHER Mary Duke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St.Mary's Co. Md.

14 Informant Lottie V.Wathen
(Address) 3412 Elgin Ave.

15 Filed APR 26 1924, 19.... Registrar
Robert F. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April.24.192[illegible]

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to April 24, 1924.
that I last saw him alive on April 24, 1924.
and that death occurred, on the date stated above, at 11:35A m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(duration) one hours yrs. mos. da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray & Microscopic Exam

(Signed) Lucille A Bayless, M. D.

4/26, 1924 (Address) 406 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 4-26-24 19

20 UNDERTAKER: H.E.Hughes — ADDRESS: 424 N.Broadway

B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86326

CERTIFICATE OF DEATH.

T93 D 86326

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Joe H Ruff

(a) RESIDENCE NO. Durham N.C. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER George T Ruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Georgia Rees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL

15 APR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to April 26, 1924, that I last saw him alive on April 26, 1924, and that death occurred, on the date stated above, at 6-18 P. m.

The CAUSE OF DEATH* was as follows:

Pyelophlebitis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Durham N.C.

Did an operation precede death? yes Date of 7/15/24

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Cecil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 27 1924

20 UNDERTAKER Joseph Ahrens

ADDRESS 2218 Guy

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks. 86327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86327

CERTIFICATE OF DEATH.

1924 D 86327

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 1-1 WARD)

2-FULL NAME Hellen Ruff.

(a) RESIDENCE No 832 Tyson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 039
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant David Easton
(Address) 916 Pa ave

15 APR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries. 2 ha Accident

(Duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo Lawton Shade, M. D.

4/26/24 192 (Address) 1426 Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Md

20 UNDERTAKER Daniel Easton

DATE OF BURIAL 4-27 1924

ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that a TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86328

CERTIFICATE OF DEATH.

90 ✓

D 86328

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 2617 Greenmount St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret E. Bahme

(a) Residence No. 2617 Greenmount St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced.~~ Married (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Bahme.

6-DATE OF BIRTH (month, day and year) July 17 1893

7-AGE. 30 yrs. 9 mos. 8 ds. If LESS than 1 day, ~~hrs. or min.?~~

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Frederick City.

PARENTS.

10-NAME OF FATHER, Georg Engelbrach.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Frederick City

12-MAIDEN NAME OF MOTHER, Susan Young.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Frederick City

14- (Informant) Mrs. Adolph Bahme

(Address) 2617 Greenmount Ave.

15- APR 27 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 25. 1924.

17- I HEREBY CERTIFY, That I attended deceased from March 10 19 24 to April 25 1924

that I last saw h.e alive on April 17 19 24

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carol Fisher, M. D

4/26. 19 24 (Address) 1823 N. Howard St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Cemetery	April 27 1924
20-UNDERTAKER, Frederick City.	ADDRESS.
Geo. J. Ruth.	1735 Harford Ave.

should be carefully supplied. Age should be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86329

CERTIFICATE OF DEATH.

109-002

D 86329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Wright

(a) RESIDENCE No. 681 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 28, 1893.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Percy D. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John A. Wright

(Address) 408 Ogston St.

15 Filed APR 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1924, to Apr. 25, 1924, that I last saw him alive on Apr. 25, 1924, and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Ludwig's Angina.

(duration) — yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Teeth Abscess.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) B. Lee Lord, M. D.

, 19 (Address) St. Jos. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 4/28 1924

20 UNDERTAKER Jas. In. Skinner

ADDRESS 1620 E. Mad. St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-24—M&T—1500 Bks.

1714 40 ✓

D 86330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86330

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO. 40

CITY OF BALTIMORE: (No. ..... ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Whiteley

(a) RESIDENCE NO. 3218 Barclay St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ressley Whiteley

6 DATE OF BIRTH (month, day, and year) Apr. 10, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER William Judson

11 BIRTHPLACE OF FATHER (city or town) N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Helen Brown

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant .....
(Address) .....

15 Filed APR 27 1924 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to April 25, 1924.

that I last saw her alive on April 25, 1924.

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis, generalized, acute

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tubo-ovarian abscesses.

Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at 3218 Barclay St.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard W. Tolman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jersey City, N. J.	Apr. 27, 24
20 UNDERTAKER	ADDRESS
Jas J. G. Locke	1302 Jeffer

ROBERT H. KRAUTER
Deputy Registrar of Vital Statistics

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86331

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 210 Walnut avenue ST., Evelea WARD 7)

2-FULL NAME James M. Harvey

(a) RESIDENCE. No. 210 Walnut avenue ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Carrie L. Harvey

6 DATE OF BIRTH (month, day, and year) Jan. 13 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Cooking Utensils

(c) Name of employer Wagner Mfg Co.

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Harvey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Dise

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Carrie L. Harvey
(Address) 210 Walnut ave. Evelea

15 APR 27 1924 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25 1924

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1924, to April 25, 1924, that I last saw him alive on April 25, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

4/26 1924 (Address) Hamilton Baltimore Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	April 28 1924
20 UNDERTAKER	ADDRESS
Fred'k Loeffler & Sons	Fullerton

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86332 D 86332

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 2143 Vine St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdelena Farter

(a) Residence No. 2143 Vaine St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, W H

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Farter

6-DATE OF BIRTH (month, day and year) March 9, 1852

7-AGE, 72 yrs. 1 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.
10-NAME OF FATHER. Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-
(Informant) Mrs. Fleet
(Address) 1036 Hanover St

15-
Filed APR 27 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Sept 20, 1923, to April 25, 1924, that I last saw h... alive on April 24, 1924, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis
Nephritis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulm Aedema

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Woodward M. D.
, 19 (Address) 1537 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Cemetery — DATE OF BURIAL, Apr 28, 1924

20-UNDERTAKER, Henry H. Weitz & Son — ADDRESS 1531 W Lombard St

Exact statement of OCCUPATION is very important and should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86333

CERTIFICATE OF DEATH.

24 1924

D 86333

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin St Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Mary L. Marshall

(Residence in Baltimore: No. 102 E Cross St ..... St., 4 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Nov 5 (Month) (Day) 1890 (Year)

7-AGE. 33 yrs. 6 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Josiah Emerson

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary E Bowersox.

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josiah Emerson

(Address) 707 Ramsay St

Burial Permit Issued

15-

APR 27 1924

ROBERT R. KRAUTER
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April 25 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(Duration) about 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Self Induced Abortion (Duration) ..... yrs. ..... mos. 19 ds.

(Signed) James M Fulton M. D.
(Coroner.)

April 25 1924 (Address) 702 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 102 E Cross

Former or usual residence 102 E Cross

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cemetery	April 28 1924

20-UNDERTAKER,	ADDRESS
Harry H Ritzke	1531 1/2 Lombard St

Spec.—1-10-21—M&T—1500 Bks.

D 86334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86334

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2005 E. Federal ST., 8 WARD)

2-FULL NAME Robert Flanigan

(a) RESIDENCE NO. 2005 E. Federal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Louisa E. Flanigan

6 DATE OF BIRTH (month, day, and year) Aug. 15 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Robert Flanigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Louisa E. Flanigan (Address) 2005 E Federal St.

15 APR 27 1924 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1924, to 4-26, 1924, that I last saw him alive on 4-26, 1924, and that death occurred, on the date stated above, at 11:55 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

, 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL April 29, 24

20 UNDERTAKER Henry Hoch & Son — ADDRESS 1301 E Eager

S. B.—WHITE PAPER should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Blks.

D 86335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 D 86335

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument & Patterson Park Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Eli

(a) RESIDENCE NO. 2017 E. Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Eli

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Eli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1429 E. Baltimore St

15 Filed APR 27 1924

ROBERT R. KRAUTER

Registrar

ROBERT R. KRAUTER, Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th, 1923 to April 27th, 1924, that I last saw him alive on April 27th, 1924, and that death occurred, on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) 1) Secondary Anemia 2) Cr. Emphysema 1) 4 mos 2) 4 mos ds.

(duration) yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 10/26/23

Was there an autopsy? No 1/10/24

What test confirmed diagnosis?

(Signed) A. Adler Landsberger, M. D.

4/27 1924 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mortuary Circle Cem DATE OF BURIAL 4/27 1924

20 UNDERTAKER Jack Levis ADDRESS 1429 E Balto St

N. B.—WRITE plainly with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 86336

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓ D 86336

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lonil Ezikowitz

(a) RESIDENCE NO. 2221 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Ezikowitz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J.Lewis (Address) 1439 E. Balto. St.

15 Date APR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy - Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

(Signed) J. E. Weiss (Coroner.), M. D.

Apr 26/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehrens Lutheran	4-27 1924
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 Eastaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

Livolsi

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86337 ✓ 80 D 86337

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N. Exeter ST. 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angel Salvator Livolsi

(a) RESIDENCE NO 410 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 13 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Jno. L. Livolsi

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Santina Fortuta

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant John Livolsi
(Address) 410 N Exeter St

15 APR 27 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 192X

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Convulsions.

Immediate cause — Pneumonia

Antecedent cause — Whooping cough (duration) 2 yrs mos ds.

Contributory (Secondary) Congenital defect 3 lobes at birth (duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

, 192 4 (Address) 1639 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	4/29/24 192
20 UNDERTAKER	ADDRESS
Jno J Beck	1736 Lanvale

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Omission to fill out each item of information called for by this certificate. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86338

CERTIFICATE OF DEATH.

11-002 ✓

D 86338

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 N. Calvert St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Elizabeth Trippe

(a) RESIDENCE NO. 1706 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced (write the word)~~: Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) July 19 - 1843

7 AGE: Years 80 Months 9 Days 7 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Joseph E. Trippe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs Loy 1706 N Calvert St

15 APR 27 1924 ROBERT P. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to April 26, 1924, that I last saw h[illegible] alive on April 26, 1924, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of the heart.

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary): Grip Infection

(duration) yrs. 11 mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Austin F. Robinson, M. D.

4/26 1924 (Address) 1307 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: April 28 19 24

20 UNDERTAKER: Geo. W. Jenkins & Son Co

ADDRESS: Druid Hill Ave & Collad

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks. Tomas Filipiak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86339

CERTIFICATE OF DEATH.

90 D 86339

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 S Bouldin ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tomas Filipiak

(a) RESIDENCE NO 1101 S. Bouldin ST., WARD 1
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislawa Filipiak

6 DATE OF BIRTH (month, day, and year) Dec .4 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	53	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer Store
(b) General nature of industry, business, or establishment in which employed (or employer) Propritor 934
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Filipiak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Stanislawa. Filipiak
(Address) 1101 S Bouldin Street

15 Medical Examiner APR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Ex Houston yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Jos Edwin Blake, M. D.
(Coroner)

4/26/24, 192 (Address) 145 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 28 1924
20 UNDERTAKER	ADDRESS
John F Weber 1803	Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86340

CERTIFICATE OF DEATH.

100-001 ✓

D 86340

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 S Wolfe St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara B. Onheiser

(a) Residence No. 710 S Wolfe St., Ward 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 2 1922

7-AGE. 1 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Peter Onheiser

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Catherine Mlynarczyk

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Mr Peter Onheiser

(Address) 710 S Wolfe Street

15- APR 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 25 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15 1924 to April 25 1924

that I last saw h~~e~~r alive on April 24 1924

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Leo Eisen M. D

1924 (Address) 826 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Holy Rosary	April 28 19 24
20-UNDERTAKER,	ADDRESS
John A Weber	1803 Bank St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

98 D 86341

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Thames ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Wisowaty (Agnes Wisowaty)

(a) RESIDENCE NO. 1628 Thames St. ST., WARD 2

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Wisowaty

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Alexandra Dobrzycki

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr John Wisowaty (Address) 1628 Thames Street

15 Filed APR 27 1924 19 HENRY R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to April 26, 1924.

that I last saw her alive on April 25th 1924

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Laryngitis

Other

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.

(Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 28 1924
20 UNDERTAKER	ADDRESS
John A. Weber	1803 Bank St

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. Terms of CAUSE OF DEATH in plain terms, so that it may be properly classified. Information should be carefully supplied. AGE is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86342

1-PLACE OF DEATH

City of BALTIMORE: (No. 8 Cereal St., Curtis Bay. Ward) 25 113

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred . Oleszczuk

(a) Residence No. 8 Cereal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 4 1923

7-AGE.	If LESS than 1 day.
— yrs. 4 mos. 21 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Boleslaus . Oleszczuk

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Felicia Balewicz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Poland

14- (Informant) Mr. Boleslaus . Oleszczuk

(Address) 8 Cereal Street

15- Filed APR 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 25 1924

17- I HEREBY CERTIFY, That I attended deceased from April 21 1924 to April 25 1924

that I last saw him alive on April 25 1924

and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute gastric indigestion.

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical examination

(Signed) N. Alpert M. D.

, 19 (Address) 2350 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross A.A.CO.	April 28, 1924

20-UNDERTAKER.	ADDRESS
John A. Weber	1803 Bank St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86343

90 D 86343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4706 Ready Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hurbert E. Young

(a) RESIDENCE NO. 504 Willow Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary O. Young

6 DATE OF BIRTH (month, day, and year) Feb 12/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Builder

9 BIRTHPLACE (city or town) (State or country) Monkton Md.

PARENTS

10 NAME OF FATHER John L. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Cummons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mary O. Young 504 Willow Ave

15 Filed APR 27 1924 192 ROBERT T. MAULER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) H S Bond, M. D. (Coroner.)

Apr 26/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westley Chapel Cem. DATE OF BURIAL Apr 28 192 4

20 UNDERTAKER W. C. Brooks ADDRESS Sparks Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instructions on back of certificate.

D 86344

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Franklin St. Hosp. St.) 16 188-006 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Rice

(Residence in Baltimore: No. 1011 N. Calhoun st St.; 12 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Sigl.

6-DATE OF BIRTH, ... (Month) ..... (Day) 1 (Year)

7-AGE, 12 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Samuel Rice

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Pearl Stagl

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Rice

(Address) 1011 N Calhoun st

15- Filed APR 27 1924 191.....

ROBERT P. KRAUTER, BURIAL PERMIT CLERK

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Apr (Month) 26 (Day) 192[illegible] (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull,

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. L. Blades M. D.
(Coroner.)

1924, (Address) 43 E. Lexington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Edenw Rosedale

DATE OF BURIAL, 4/27, 1924

20-UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

D 86345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86345

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2538 Druid Hill ave St., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fanny Cotler

(a) RESIDENCE No. 2538 Druid Hill ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? 27 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: David Rosenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Lena Dumpth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Wm Cotler

(Address) 2538 Druid Hill ave

15 Filed APR 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1923, to April 26, 1924,

that I last saw her alive on April 26, 1924;

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema & Bronchitis

disease (duration) 1½ yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A Abrams, M. D.

April 27 1924 (Address) 2360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Washington Rd

DATE OF BURIAL: 4/27 1924

20 UNDERTAKER: Sol Shinsonor Bro

ADDRESS 127 E Baltimore St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86346

CERTIFICATE OF DEATH.

49

D 86346

1-PLACE OF DEATH

City of BALTIMORE: (No. 735 N. North Ave St. 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Franklin McCauley

(a) Residence No. 735 N. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L. McCauley

6-DATE OF BIRTH (month, day and year) March 22-1848

7-AGE, 76 yrs. 1 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pattern Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 5 years

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Laurel Maryland

PARENTS.

10-NAME OF FATHER, Levy M. McCauley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Gott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Miss Eddie McCauley

(Address) 735 N. North Ave

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

APR 27 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26-1924

17- I HEREBY CERTIFY, That I attended deceased from 17th Apl., 1924, to 26 Apl., 1924, that I last saw him alive on 26 April, 1924, and that death occurred, on the date stated above, at 9.25 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(Duration) 1 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & Clinical Exam

(Signed) Vance W. Boyer, M. D.

27 Apl. 1924 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn — DATE OF BURIAL, April 29 1924

20-UNDERTAKER, Horace H. Burgee — ADDRESS 3631 Falls Road

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86347

CERTIFICATE OF DEATH.

101-001 ✓ D 86347

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 335 W. 21st St. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Hanna

(a) RESIDENCE NO. 335 W. Twenty First ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Hanna

6 DATE OF BIRTH (month, day, and year) July 30, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engine Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Hanna

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jane Hanna
(Address) 335 W. 21st Street

15 APR 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1924.

17

I HEREBY CERTIFY, That I attended deceased from Apr 21. 1924, to Apr 26 1924,

that I last saw him alive on Apr 25 1924

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W H Sharp M. D.

. 19 (Address) 205 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Liberty — DATE OF BURIAL April 29 1924

20 UNDERTAKER E. LeRoy Stiffler — ADDRESS 125 E. North ave.

N. B.—WRITE PLAINLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86348

CERTIFICATE OF DEATH.

74-002

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 7 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Hedges

(a) Residence No. 19 Montier Ave St., Ward.....

(Usual place of abode) 4802 Delaware Ave. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura E Hedges

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day. hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Accountant

(b) General nature of Industry, business, or establishment in which employed (or employer) Coal

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER. John Hedges

11-BIRTHPLACE OF FATHER (city or town) (State or Country), West Va.

12-MAIDEN NAME OF MOTHER. Mary Lightner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), West Va.

14- (Informant) Municipal Hospital Records

(Address)

15- APR 27 1924 ROBERT E. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-24-24

17- I HEREBY CERTIFY, That I attended deceased from 4-19, 1924 to 4-24 19 24

that I last saw him alive on 4-24 19 24

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Left Hemiplegia (Thrombotic)

(Duration) yrs. mos. 5 ds. per

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sal.

(Signed) Claude G. Bruce M. D.

4-25 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bel Air Md Gatches

DATE OF BURIAL. April 28 24

20-UNDERTAKER. E. LeRoy Stiffler

ADDRESS 125 E. North Ave.

should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D 86349

D 86349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hall Tyson

(a) RESIDENCE NO. 1916 E. Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lillie E Tyson

6 DATE OF BIRTH (month, day, and year) Jan 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Anyone

9 BIRTHPLACE (city or town) Delaware
(State or country)

PARENTS

10 NAME OF FATHER Elijah Tyson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carobella Rosa

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed APR 21 1924 ROBERT R. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-26, 1921, to 4-26, 1924, that I last saw him alive on 4-25, 1924, and that death occurred, on the date stated above, at 12 35 a.m.

The CAUSE OF DEATH* was as follows:

Senile Detinction
Chronic Infection
Arthritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia
(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sal

(Signed) Claude B. Hane, M. D.

4-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Apr 28 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fort Ave

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86350

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86350

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 N. Bradford St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Biscoe

(a) Residence No. 1607 N Bradford St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 26 1894

7-AGE.	If LESS than 1 day,
30 yrs. 2 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Peck Bros 086

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Geo. F Biscoe

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country).....

12-MAIDEN NAME OF MOTHER Julia Mueller

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country).....

14- (Informant) Geo. F Biscoe

(Address) 1607 N Bradford

APR 27 1924

ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 24 1924

17- I HEREBY CERTIFY, That I attended deceased from April 20 19 24 to April 24 19 24

that I last saw h... alive on April 23 19 24

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

one

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirm Diagnosis?.....

(Signed) Carroll J Cook M. D

4/26 1924 (Address) 1137 Washington

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park.	Apr 28 1924
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E Lombard

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 86351

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 ✓

D 86351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2222 N. Calvert St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harris Edwards Greene

(a) Residence No. 2222 N. Calvert St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX —

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William H.

6-DATE OF BIRTH (month, day and year) May 5, 1838

7-AGE. 86 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Hon Wm B. Edwards

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Elizabeth Somerville

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Edwd S Greene

(Address) 2222 N. Calvert

15- APR 27 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from April 9th 1924 to April 26 1924

that I last saw her alive on April 26 1924

and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows:

General Bronchitis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus A. Johns M. D

4/26/ 1924 (Address) 3014 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. April 25 1924.

20-UNDERTAKER. Wm Cook ADDRESS 932 Park Ave

N. B.—WRITE CAREFULLY. All items should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86352

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3335 Brook Ave St., 13 Ward) Hampden

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Fiet

(a) Residence No. 3335 Brook Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced, (Write the word.)
Male	white	married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Laura E Fiet

6-DATE OF BIRTH (month, day and year) Sept 24 1851

7-AGE. 72 yrs. 7 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)..... Mills

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Pa

PARENTS.

10-NAME OF FATHER. George H Fiet

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Rebecca Emery

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Pa

14- (Informant). Laura Fiet

(Address) 3335 Brook Ave

15- APR 27 1924 ROBERT E. [illegible] Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from January, 1923, to April 26, 1923, that I last saw h. alive on April 23, 1923, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tumor + Gastric Symptoms

(Signed) R L Tennent, M. D.

April 26, 1924 (Address) 3340 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Harmony Hampden DATE OF BURIAL. Apr 27 1924

20-UNDERTAKER. [illegible] for E Young ADDRESS

N. B.—WHITE PENCIL should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Stated CAUSE OF DEATH should be carefully classified. Exact statement of OCCUPATION is very important. Stated CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86353

CERTIFICATE OF DEATH.

90 D 86353

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 501 Franklin Terrace St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hallie James Meads

(a) Residence No. 501 Franklin Terrace St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James C. Meads

6-DATE OF BIRTH (month, day and year) Dec. 21 1856

7-AGE, 67 yrs. 4 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, David Curtis Bennett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Blanche L. Richardson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

11- (Informant) Mr. David C. Meads

(Address) 501 Franklin Terrace

15- APR 27 1924 ROBERT R. KRAUTCH, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 25 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1923, to Apr. 25, 1924, that I last saw h E.P. alive on Apr. 25, 1924, and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis.* Clinical

(Signed) H W Wheaton M. D

, 19 (Address) 4235 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. | DATE OF BURIAL, Sept. 28 1924

20-UNDERTAKER: Wm Fickenscher Sons | ADDRESS North & Pa

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86354

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 86354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2504 Edmondt St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Williams Wilson

(a) Residence No. 2504 Edmondt St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary B Wilson

6-DATE OF BIRTH (month, day and year) March 4-1853

7-AGE.	If LESS than 1 day,
71 yrs. 1 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Farmer

9-BIRTHPLACE (city or town) Kent Co
(State or Country), Delaware

PARENTS.

10-NAME OF FATHER Thomas W Wilson

11-BIRTHPLACE OF FATHER (city or town) Kent Co
(State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Mary Schram

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Delaware

14-

(Informant) Thomas William Wilson

(Address) 2504 Edmondt Ave

15-

Filed APR 27 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr-25/24

17- I HEREBY CERTIFY, That I attended deceased from Apr 18 1924 to Apr 25 1924

that I last saw him alive on Apr 25 1924

and that death occurred, on the date stated above, at 4-40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency with pulmonary infarctions Chronic and hypostatic Pneumonia (Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Stanley Cole M. D.

4/26, 1924 (Address) 2502 Garrison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Dover Del	Apr 28, 1924
20-UNDERTAKER,	ADDRESS
D. E. Tindall & Sons	Dover

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

This certificate, if it may be properly classified, so that it may be in plain terms, so that it may be

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86355

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 86355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1 Talbott Road St. (Ward) 15 Windsor Hills

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Menkert

(a) Residence No. 1 Talbott Road St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick Menkert

6-DATE OF BIRTH (month, day and year) Dec. 6, 1851

7-AGE. 72 yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Wm Ulbrick

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Christine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant). Mrs J. R. Adams

(Address) 1 Talbot Road.

15-

APR 27 1924

Burial Permit Clerk.

Registrar.

ROBERT R. KRAUTER.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 26 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 15 1924 to Apr 26 1924

that I last saw h.. alive on Apr 25 1924

and that death occurred, on the date stated above, at 2 to a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ....yrs. ....mos. 11 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter E. Nesbitt, M. D

Apr 26 1924 (Address) 2220 Harrison ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Apr 28 1924
20-UNDERTAKER. Wm J. Rickuks & Sons	ADDRESS. North & Pa

Should be carefully supplied. Exact statement of OCCUPATION is very important. Also in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 86356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linnie Ziegler

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 APR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-27 1924

17

I HEREBY CERTIFY, That I attended deceased from 11-9, 1923, to 4-27, 1924

that I last saw her alive on 4-26, 1924

and that death occurred, on the date stated above, at 4:00 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Clark G. Drew, M. D.

4-27 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harbaugh Cemetary	April 27, 24
20 UNDERTAKER	ADDRESS
George E. J. Smith	1537 Pulaski Hwy

R. B. ... should be carefully supplied. AGE should be stated ... mation should be carefully supplied. Exact statement of OCCUPATION ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86357.

CERTIFICATE OF DEATH.

X 49 D 86357.

JOHNS HOPKINS HOSPITAL.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Butts

(a) RESIDENCE No. 2024 Hubbard St. Jacksonville Fla.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign Birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Lela Butts

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy Worker

(b) General nature of industry, business, or establishment in which employed (or employer) — 886

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Fla.

PARENTS

10 NAME OF FATHER Joseph Butts

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Martha Gay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 28 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to April 27, 1924, that I last saw h[illegible] alive on April 27, 1924, and that death occurred, on the date stated above, at 4.25 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder
with Metastases

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Jacksonville Fla.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic examination and X-Ray

(Signed) Wm. H. Deaver, M. D.

(Address) Johns Hopkins Hospital, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jacksonville Florida — DATE OF BURIAL April 28 1924

20 UNDERTAKER Chas. E. Franck Sons — ADDRESS Madison Ave

INFORMATION should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86358

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1910 McCulloh St., 14 Ward) 45

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Diggs

(a) Residence No. 1910 McCulloh St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Diggs

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 48 yrs. mos. ds.

If LESS than 1 day, hrs. or. mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Thos. Coates

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Martha Curtis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs. Ida Diggs

(Address) 1910 McCulloh

15- Filed APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/25/24

17- I HEREBY CERTIFY, That I attended deceased from March 10 1924 to April 25 1924

that I last saw h.. alive on April 25 1924

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Peritoneal Carcinoma

(Duration) 6 7/1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4/16/24

Was there an autopsy? no

What test confirmed diagnosis? H. S. McCard

(Signed) H. S. McCard M. D.

4/26, 1924 (Address) 2005 Hollins

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Mt. Auburn Cemetery	April 29 1924
20-UNDERTAKER.	ADDRESS
Mrs. Katie R. Williams	322 N. Schroeder St.

should be carefully supplied. Exact statement of OCCUPATION is very important. Cause of death must be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86359

CERTIFICATE OF DEATH.

701-801

D 86359

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 154 Dolphin ST., 11 WARD)

2-FULL NAME Mabel Gertrude Bowen

(a) RESIDENCE NO. 154 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred whole life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 1 — 1901

7 AGE	22 Years	6 Months	25 Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Susie Bowen

(Address) 154 Dolphin St.

15 Filed APR 28 1924 ROBERT F. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25 - 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1924, to Apr. 25, 1924, that I last saw her alive on Apr. 25 -, 1924, and that death occurred, on the date stated above, at 5:59 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Chas. T. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 28 1924.
20 UNDERTAKER	ADDRESS 322 N. Schroeder St
Mrs. Katie R. Williams	

N. B. All information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 86360

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 86360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Isbell

(a) Residence No. 648 W. Hoffman St. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unkn.

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Va

PARENTS.

10-NAME OF FATHER, Unkn.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do

11- (Informant) Bay View Hospital

(Address).....

15- Filed APR 28 1924 ROBERT P. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from July 22 1922 to April 26 1924 that I last saw him alive on April 26 1924 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia.

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General Paralysis

(Duration) Unkn mos. ds.

18-Where was disease contracted if not at place of death? Unkn

Did an operation precede death? Yes Date of.....

Was there an autopsy? Not

What test confirmed diagnosis? Clinic & Lab

(Signed) H. J. Arnold M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Ashonalloy Va

DATE OF BURIAL. 4-26 1924

20-UNDERTAKER. Emil E Easton

ADDRESS 916 Eutaw

should be carefully supplied. Exact statement of OCCUPATION is very important and will be properly classified. Exact statement of CAUSE OF DEATH should be carefully supplied. All words should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important and instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86361

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86361

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Fr Sq Hospital 16 ST., ... WARD)

2-FULL NAME Constance Vinci

(a) RESIDENCE No. 2915 Harlem ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3		26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work nn
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Peter Vinci

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Teresa Vinci

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Peter Vinci
(Address) 2915 Harlem ave

15 APR 28 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns 2nd & 3rd Degree.

Duration 1 day

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Rodey, M. D.
(Coroner)

4/26/24 192 (Address) 143 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	4-28 1924
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

CAUSE OF DEATH must be filled in plain terms, so that it may be understood. See instructions on back of certificate.
TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86362

CERTIFICATE OF DEATH.

15 122 002

REGISTERED NO. D 86362

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1918 Walbrook Ave ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) 15 WARD)

2-FULL NAME Mary K. Willson

(a) RESIDENCE. No. 1918 Walbrook Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Emerson Drug Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Willson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary McCubbins

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary Clara Willson
(Address) 1918 Walbrook Ave.

15 Filed APR 28 1924 19

ROBERT P. KRAUTZ
Assistant
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 23rd, 1923, to April 25, 1924, that I last saw her alive on April 24th, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Joint

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald I. Tonry, M. D.

4-26, 1924 (Address) 1414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 27 1924
20 UNDERTAKER	ADDRESS
Martin Fahey & Son	627 N. North

INSTRUCTIONS—Items must be properly classified. Each statement must be full and accurate. Do not use abbreviations or characters. Write plainly with pen and ink. Do not use lead pencil. Do not write in margins or between lines. Avoid erasures. Consult your family and neighbors before answering questions if you are not certain of the facts yourself. Make every answer complete. Where there is no entry to be made, write "None" or "Unknown" as the case may be. Do not refer to any other certificate or statement for information. Do not state cause of death in terms of mode of dying, such as heart failure, asphyxia, etc., but give the disease causing such condition. Indefinite or unsatisfactory causes of death will be returned for correction. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be full and accurate. Do not use abbreviations or characters. Write plainly with pen and ink. Do not use lead pencil. Do not write in margins or between lines. Avoid erasures. Consult your family and neighbors before answering questions if you are not certain of the facts yourself. Make every answer complete. Where there is no entry to be made, write "None" or "Unknown" as the case may be. Do not refer to any other certificate or statement for information. Do not state cause of death in terms of mode of dying, such as heart failure, asphyxia, etc., but give the disease causing such condition. Indefinite or unsatisfactory causes of death will be returned for correction. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be full and accurate. Do not use abbreviations or characters. Write plainly with pen and ink. Do not use lead pencil. Do not write in margins or between lines. Avoid erasures. Consult your family and neighbors before answering questions if you are not certain of the facts yourself. Make every answer complete. Where there is no entry to be made, write "None" or "Unknown" as the case may be. Do not refer to any other certificate or statement for information. Do not state cause of death in terms of mode of dying, such as heart failure, asphyxia, etc., but give the disease causing such condition. Indefinite or unsatisfactory causes of death will be returned for correction. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement must be full and accurate. Do not use abbreviations or characters. Write plainly with pen and ink. Do not use lead pencil. Do not write in margins or between lines. Avoid erasures. Consult your family and neighbors before answering questions if you are not certain of the facts yourself. Make every answer complete. Where there is no entry to be made, write "None" or "Unknown" as the case may be. Do not refer to any other certificate or statement for information. Do not state cause of death in terms of mode of dying, such as heart failure, asphyxia, etc., but give the disease causing such condition. Indefinite or unsatisfactory causes of death will be returned for correction. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86363

CERTIFICATE OF DEATH.

100-001

D 86363

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hopkins

(a) Residence No. 101 E. Bruce Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1854.

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Caroline Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Boy, Next of Kin

(Address) Unknown

15- Filed APR 26 1924 ROBERT P. BRADDY, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/24/24.

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1924 to April 24, 1924.

that I last saw her alive on April 24, 1924.

and that death occurred, on the date stated above, at 12-5 A. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fuller M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL, 4-26 19 24

20-UNDERTAKER, David Easton

ADDRESS 916 Penna ave

should be carefully supplied. Exact statement of OCCUPATION is very important. Cause of death must be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86364

CERTIFICATE OF DEATH.

31 ✓

REGISTERED NO. D 86364

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Vine ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Sampson

(a) RESIDENCE NO. 815 Vine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Christina Sampson

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Granite Polisher

(b) General nature of Industry, business, or establishment in which employed (or employer) 076

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D-C.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Christina Sampson (Address) 815 Vine St

15 Filed APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 15, 1924, to Apr 24, 1924, that I last saw him alive on Apr 23, 1924, and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

according to history

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis?

(Signed) William Frey, M. D.

4/24 1924 (Address) 1928 Fa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 4-26 1924

20 UNDERTAKER Orrel Easton — ADDRESS 916 Ca ave

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86365

CERTIFICATE OF DEATH.

128 D 86365

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 Bowers Court ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Franklin

(a) RESIDENCE NO. 224 Bowers Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Huskey Franklin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Catonsville Md.

PARENTS

10 NAME OF FATHER Benjiman Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Catonsville Md.

14 Informant Katie Tripps (Cousin)
(Address) 1019 N. Stricker

15 APR 26 1924 Filed , 19 ROBERT T. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/1924 19

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1924 19 to April 23, 1924 19

that I last saw her alive on April 23rd. 1924

and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows:
Acct. Parenchymatous Nephritis

(duration) yrs. mos. 5 ds.
Alcholism

CONTRIBUTORY (Secondary)

(duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4-28 1924

20 UNDERTAKER David Easton

ADDRESS 916 Pa ave

mation should be carefully supplied. Age should be given in years, months and days. Exact statement of occupation is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Danoff)

D 86366 HEALTH DEPARTMENT CITY OF BALTIMORE D 86366

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Heb Hosp ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Danoff

(a) RESIDENCE NO. 1116 E Baltimore ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 15 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	14	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Hyman Danoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Kaselowsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hebrew Hospital (Address) Balto

15 Filed APR 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to April 27, 1924, that I last saw h[illegible] alive on April 27, 1924, and that death occurred, on the date stated above, at 11:55 A.M. (Cause)

The CAUSE OF DEATH* was as follows: Postoperative Shock

(duration) yrs. mos 1 dy ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/25/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Keller Sondheimer, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	4/28 1924
20 UNDERTAKER	**ADDRESS**
Jack Lewis 1934	E Balto

mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86367 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86367

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Klodek (Klodek)

(a) RESIDENCE NO. 612 S. Chapel St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) June 22/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Walter Klodek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Marie Jakubowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Walter Glodek (Address) 612 S Chapel St

15 APR 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collins, M. D.
(Coroner.)

Apr 28/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Apr 28 1924
20 UNDERTAKER	ADDRESS
F W Ozarowski	1230 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86368

CERTIFICATE OF DEATH.

161-001

D 86368

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S. Fifteenth ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Michael & Catherine Fitz.

(a) RESIDENCE NO. 606 S. Fifteenth ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	b and miscarriage

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		6 month miscarriage		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael F. Fitz.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Eggenhofer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant M. F. Fitz
(Address) 606 S Fifteenth St

APR 28 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26- 1924 to April 27- 1924.

that I last saw h in live on April 26 1924,

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth.
6 and. miscarriage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Allen E. Bratham, M. D.

4-27 1924 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	April 28 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86369

D 86369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2147 Market St. (out Whims) St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... William Henry Bonsall

(a) Residence No... 2147 Market St., 26 Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Emma V. Bonsall

6-DATE OF BIRTH (month, day and year) June 14. 1862

7-AGE, 61 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)... Shipbuilder

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Towson Balto Co. Md

PARENTS.

10-NAME OF FATHER Robert F. Bonsall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Martha Pierce

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Co. Md

14- (Informant) Mrs Emma V. Bonsall

(Address) 2147 Market st

15- Filed ... 192... ROBERT R. KRAETER Registrar.

APR 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 3 1924 to April 26 1924

that I last saw him alive on April 25 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Crasis

Paralysis Flenard

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? ... Date of...

Was there an autopsy?...

What test confirmed diagnosis?...

(Signed) Geo. L. Zimmerman M. D.

4/28 1924 (Address) 1257 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL, April 29 1924

20-UNDERTAKER, Jos Joerdens & Son ADDRESS 217 S. Paca st

Should be carefully supplied. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. Exact instructions on back of certificates.

D 86370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86370 Registered No. C 179

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Dorothy L. Hicks

(Residence in Baltimore: No. 122 S. Carrollton Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word)
Female	white	Single

6-DATE OF BIRTH. Aug (Month) 5 (Day) 1917 (Year)

7-AGE. 6 yrs. 8 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Salt Lake City

PARENTS.

10-NAME OF FATHER. Wm L Hicks

11-BIRTHPLACE OF FATHER. (State or Country). Salt Lake City

12-MAIDEN NAME OF MOTHER. Isabella Steed

13-BIRTHPLACE OF MOTHER. (State or Country). Salt Lake City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm L. Hicks

(Address) 122 S. Carrollton Ave

15- APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

Filed ... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 26 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fr Burns over body
arms & legs, which
having will Candle
Accidental (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Burns & Scalds

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

April 27 1924 (Address) 7 W Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Olivet Cem	April 28 1924
20-UNDERTAKER.	ADDRESS.
John O. Mitchell	1201 W Fayette St

N. B.—Every item of information should be carefully supplied, that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86371

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86371

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital (Ward) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Byrnes

(a) Residence No. 509 S. Register st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Byrnes

6-DATE OF BIRTH (month, day and year) 1904

7-AGE.	If LESS than 1 day,
20 yrs. ..... mns. ..... ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm. Dinsmore

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Nellie Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

APR 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 25 1924 to April 26 1924

that I last saw her alive on April 26 1924

and that death occurred, on the date stated above, at 4.12 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally, M. D.

4-26-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Patrick's Cemetery

DATE OF BURIAL. April 29 1924

20-UNDERTAKER. H. Sander & Sons

ADDRESS 1710 Fleet St.

Should be carefully supplied. Exact statement of occupations is necessary, in order that deaths may be properly classified. Use only common or generally accepted abbreviations. Write plainly, in ink, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86372

CERTIFICATE OF DEATH.

D 86372

90

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1641 Westwood ave ST., 15 WARD)

2-FULL NAME Frank B Thomas

(a) RESIDENCE NO. 1641 Westwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Information is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph A Thomas

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Redmond

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Juliet L Thomas
(Address) 1641 Westwood Ave

15 Filed APR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

April 26, 1924 (Address) 2882 Eutaw Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 28 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86373

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Women Home St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L. Rea

(a) Residence No. Aged Women Home St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	Wht	✓

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 25 1837

7-AGE,	If LESS than 1 day,
87 yrs. 6 mos. ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER, James Rea

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Waddell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Ella F. Jones

(Address) 1410 W. Lexington st.

15- Filed APR 28 1924 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 10, 1923, to Apl 25, 1924, that I last saw h... alive on Apl 25, 1924, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebro-Sclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W J Horwood, M. D.

April 26, 1924 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Co	April 28, 1924
20-UNDERTAKER, George J Smith	ADDRESS 153 Hollins st

Exact statement of OCCUPATION is very important. Entries must be made in plain terms, so that it may be properly classified. Entries should be typewritten or written with pen and ink. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D 86374

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3907 Edmondson Ave. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Lewis Green,.....

(a) Residence No.... 3907 Edmondson Ave. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna May Green

6-DATE OF BIRTH (month, day and year) March 1854

7-AGE,	If LESS than 1 day,
70 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired Policeman

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 61

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph A.Green

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Groncwell, APR 28 1924

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Anna May Green

(Address) 3907 Edmondson Ave.

15- APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) APR 26 1924

17- I HEREBY CERTIFY, That I attended deceased from April 21, 19 24, to April 25, 19 24

that I last saw h. alive on April 25, 19 24

and that death occurred, on the date stated above, at 1.30 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

.....

.....

.....

.....(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

.....(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) W. T. Lorrin, M. D.

, 19 (Address) 340 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral

DATE OF BURIAL, APR 29 1924, 19....

20-UNDERTAKER, Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Should be carefully prepared in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86375

CERTIFICATE OF DEATH.

D 86375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 N. Milton ave ST., 4 WARD)

2-FULL NAME Fortina Bryan

(a) RESIDENCE NO. 1108 N. Milton ave ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A. Bryan

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Hubbard

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Trego

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Fannie P. Schmidt
(Address) 1108 N. Milton ave

15 APR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 26, 1924, that I last saw h alive on April 26, 1924 and that death occurred, on the date stated above, at 11.15 A. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) J. Fred Rumbley M. D.

4-27, 1924 (Address) 600 N. Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 4/29 1924

20 UNDERTAKER Perkins & Perkins

ADDRESS 1739 Eager

Information should be carefully supplied. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 86376

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. ..... ST., 8 WARD)

2-FULL NAME Margaret Steck

(a) RESIDENCE NO. 2026 E Biddle St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Steck

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Katie Walters

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 APR 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1924

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to April 25, 1924, that I last saw her alive on April 25, 1924, and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH was as follows: Chronic Rheumatic Endocarditis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thos. R. Boggs, M. D. Johns Hopkins Hospital

19 Filed ..... 19 .....

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 4/29 1924

20 UNDERTAKER Parkland Pickler

ADDRESS 1739 Eager

Information should be carefully supplied. Exact statement of OCCUPATION should be properly classified. See that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86377

CERTIFICATE OF DEATH.

129 D 86372

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 Born alley ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Kennard

(a) RESIDENCE NO. 830 Born alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced: (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1896

7 AGE — Years: 27 Months: 8 Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Rosetta Hall (Address) 1021 Carlton St

15 APR 28 1924 ROBERT R. KRAUTER, Registrar of Records

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24. 1924, to April 26. 1924.

that I last saw h[illegible] alive on April 25. 1924.

and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos 1 dy.

CONTRIBUTORY (Secondary) Bright Disease Complic[illegible] Cardiac Disease (duration) yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr S W Kennard M. D.

4-27 1924 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Apr 28 1924

20 UNDERTAKER: David B Hensley

ADDRESS: 1738 W Balto

mation should be carefully supplied. Age above CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

86378

CERTIFICATE OF DEATH.

90 D 86378

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N. Kenwood Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. O'Neil

(a) RESIDENCE NO. 401 N. Kenwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary M. O'Neil

6 DATE OF BIRTH (month, day, and year) May 3/53

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Peter O'Neil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary M. O'Neil (Address) 401 N. Kenwood Ave

15 Filed APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov 12, 1923, to April 25, 1924.

that I last saw h alive on April 25, 1924,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Fatty Degeneration of Heart

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Influmation of Spine (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn M. D.

4/26 1924 (Address) 3907 Garrison Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 4/28 1924

ADDRESS 2016 Orleans

20 UNDERTAKER Philip Hennig

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. INFORMATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec- 12-23-21 - R.B.R.S.-400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86379

CERTIFICATE OF DEATH.

31 ✓ D 86379

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Clark

(a) Residence No. 333 Font Hill ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 3 1894

7-AGE. 29 yrs. 9 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER, Edwin C. Clark

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Washington, D.C.

12-MAIDEN NAME OF MOTHER, Mary H. Mooney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

11- (Informant) Hospital Records

(Address) M.T.H.

15- Filed APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 25 to 24 to April 26 to 24

that I last saw him alive on April 26 to 24

and that death occurred, on the date stated above, at 6.20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous osteomyelitis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) L. A. Kelly M. D

Apr. 26 19 24 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	April 2 19 24
20-UNDERTAKER	ADDRESS
F. B. Westport	725 Fulton Ave

Should be carefully prepared. Exact statement of occupations is necessary. Cause of death must be classified. Exact statement of cause must be given in plain terms, so that it may be properly classified. Consult instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86380

CERTIFICATE OF DEATH.

D 86380

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4108 E. Lombard St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia L. Parrish

(a) Residence No. 4108 E. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) married

5a-~~If married, widowed, or divorced~~ (HUSBAND of (or) WIFE of) Edgar L Parrish

6-DATE OF BIRTH (month, day and year) Jan 31-1873

7-AGE, 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Betz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant, Edgar L. Parrish

(Address) 4108 E. Lombard St

15-Filed APR 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 25-1924

17- I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to April 25, 1924

that I last saw her alive on April 25, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma

Cerebral Hemorrhage

(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease (Duration) X yrs. 6 mos. X ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jas L. Pinard M. D.

April 26, 1924 (Address) 248 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: April 28, 1924

20-UNDERTAKER: Robt J Turner Jr — ADDRESS: 1422 N Broadway

Should be carefully supplied. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86381 HEALTH DEPARTMENT—CITY OF BALTIMORE 58-001 D 86381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hosp. St., 21 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Daily

(a) Residence No. 1012 N. Paca St. City Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M | 4-COLOR OR RACE, W. | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 1889

7-AGE. 35 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Helper. 086
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.
10-NAME OF FATHER, Timothy Dailey
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Mary Noonan
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mary E Daily
(Address) 1012 N Paca St.

15- Filed ... 192... ROBERT R. KRAUTER, Registrar.
APR 28 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924 to April 26 1924
that I last saw him alive on " 26 1924
and that death occurred, on the date stated above, at 11 45 a. m.
The CAUSE OF DEATH* was as follows:

Aplastic Anemia
(Duration) ... yrs. ... mos. 25 ds.
CONTRIBUTORY (Secondary) Cardiac Failure
(Duration) ... yrs. ... mos. 5 ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Blood examination

(Signed) S. Goldman, M. D.
, 19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cemetery	April 29. 1924.
20-UNDERTAKER	ADDRESS
Dennis Dignan & Son	Power Block

Should be carefully examined as to Exact statement of Occupations, in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86382

CERTIFICATE OF DEATH.

161-901 D 86382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Edmondson Av ST.; 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Tyler

(a) RESIDENCE. No. 906 Edmondson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Annotation	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✗ None

(b) General nature of industry, business, or establishment in which employed (or employer) ✗

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Nellie Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Howard Tyler
(Address) 906 Edmondson Av

15 Filed APR 28 1924 ROBERT P. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to April 26, 1924, that I last saw h[illegible] alive on April 26, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Birth

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✗

Did an operation precede death? ✗ Date of ✗

Was there an autopsy? ✗

What test confirmed diagnosis? ✗

(Signed) H. Hammerschlag M. D.

Apr 27 19 (Address) 8 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 28 1924
20 UNDERTAKER	**ADDRESS**
James Dignam & Son	1000 S. Paca St

mation should be carefully prepared, so that it may be properly classified. Exact statement of disease
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86383

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86383

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Edmondson Ave. WARD 16)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tyler

(a) RESIDENCE. No. 906 Edmondson Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Premature	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Nellie Stack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Howard Tyler

(Address) 906 Edmondson Ave

15 APR 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to April 26, 1924, that I last saw h[illegible] alive on April 26, 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

Birth

(duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of X

Was there an autopsy? X

What test confirmed diagnosis? X

(Signed) [illegible] M. D.

April 26, 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 28 1924
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

59-001 ✓

15 D 86384

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Tivoly ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles William Kaiser

(a) RESIDENCE. NO. 2718 Fennich ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. 2 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male Boy

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Feb. 15-24

7 AGE: Years — Months: 2 — Days: 12 — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto md

PARENTS

10 NAME OF FATHER: Robert Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: Louisa Otto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant (Address): Mrs Louisa Kaiser 2701 Tivoly ave

15 Filed ..... 19 ..... ROBERT H. KRAUSE, Registrar. Burial Permit Clerk.

APR 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1924, to April 27, 1924, that I last saw him alive on April 17, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Hydrocephalis

(duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. F. Zimmerman M. D.

4/27/1924 (Address) 2256 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: April 28 1924

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 86385

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Schaffer Ave ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Kennedy

(a) RESIDENCE. No. 2 Schaffer Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Warren Kennedy

6 DATE OF BIRTH (month, day, and year) Jan 19-1896

7 AGE 28 Years | Months 3 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Md

PARENTS

10 NAME OF FATHER Clifford M Darrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minty E Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Emily R. Tollenger 3514 Fairview Ave

Filed APR 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10 1924, to April 26 1924, that I last saw h alive on 11 25 1924, and that death occurred, on the date stated above, at 1 30 a m.

The CAUSE OF DEATH* was as follows:

Phthisis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? no Date of —

Was there an autopsy? no. Clinical

What test confirmed diagnosis?

(Signed) G. C. Deacon, M. D.

4/26 1924 (Address) 3907 Jackson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 29 1924
20 UNDERTAKER	ADDRESS
John H. Denny	715 Light St

mation should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001 ✓

D 86386

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Locust Point Yard. B & O R R Co. ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Hartig.

(a) RESIDENCE NO 2013 Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 6 mos. 27 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Margaret Hartig.

6 DATE OF BIRTH (month, day, and year) September 30, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakesman
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Hartig.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Trittau.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William G. Hartig. (brother). (Address) 1702 S. Charles St.

15 APR 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over and cut in two by engine #372 B & O R R Co. Occidental death.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

April 28, 192 4 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 4/28 192 4

20 UNDERTAKER J. Few McCully ADDRESS 130 E. Fort

TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D 86387 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 ✓

CERTIFICATE OF DEATH D 86387

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 15 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rosenfield

(a) RESIDENCE NO. 2416 Presbury ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White Hebrew	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 24 1924

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4 1/2 Intrauterine		Extrauterine

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob L. Rosenfield

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sarah Seliterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Jacob L. Rosenfield (Address) 2416 Presbury St.

APR 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to 4 20 P. M. April 24, 1924, that I last saw him alive on April 24, 1924, and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows: Prematurity (4 1/2 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno Crampton, M. D.

19 (Address) MD Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Md. Gen'l Hosp.	
20 UNDERTAKER	ADDRESS

mation should be carefully supplied. Exact statement of occupa... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 86388

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Orchard ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Queen

(a) RESIDENCE NO. 523 Orchard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Jennie Queen

6 DATE OF BIRTH (month, day, and year) Jan 12, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Daniel Queen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Holland

13 BIRTHPLACE OF MOTHER (city or town) West Point
(State or country) Md

14 Informant Roberta Lee
(Address) 706 E Monument St

15 Filed ....19.... ROBERT R. KRAUTER, Registrar
APR 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7th, 1924 to Apr. 25th, 1924,
that I last saw him alive on April 24th, 1924,
and that death occurred, on the date stated above, at 7:20 a. m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of the heart

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Ken Edwards, M. D.

4/25, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	April 1924
20 UNDERTAKER	ADDRESS
Mrs R. C. Elliott	227 Eastland Ave

mation should be carefully supplied. Avoid abbreviations. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86389

1-PLACE OF DEATH D 86389

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

2-FULL NAME David Jordan

(a) RESIDENCE NO. 716 Pierce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Record
(Address) UNIVERSITY OF MARYLAND.

15 Filed APR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24-1924

17 I HEREBY CERTIFY, That I attended deceased from 4-17-, 1924, to 4-24, 1924

that I last saw him alive on 4-24, 1924

and that death occurred, on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic myocarditis

Myocardial insufficiency

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ext.

(Signed) Claude T. Dean, M. D.

4-24-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS APR 28 1924

Per Wm. R. Woodall

mation should be carefully supplied. Age must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

33

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86390 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 ✓ D 86390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St Agnes Hospital 27 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dorsey

(a) Residence No. 23 Belvedere Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Loretta Dorsey

6-DATE OF BIRTH (month, day and year) June 3-1887

7-AGE. 36 yrs. 9 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) 029
(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) England

PARENTS.
10-NAME OF FATHER, John Dorsey
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12-MAIDEN NAME OF MOTHER, Mary A Gordon
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14-(Informant) Mrs Loretta Dorsey
(Address) 23 Belvedere Ave

15-Filed APR 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26-24

17-I HEREBY CERTIFY, That I attended deceased from April 19 19 24 to April 26 19 24
that I last saw h.. alive on April 26 19 24
and that death occurred, on the date stated above, at 7.20 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardio-Nephritis ?

Hypertension (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. Exam.

(Signed) S. Goldman M. D

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Catholic Cemetery — DATE OF BURIAL. 4/29/ 1924

20-UNDERTAKER. Chas F. Braud & Son — ADDRESS 1180 W. Lafayette Ave

Should be carefully supplied, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86391 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 133 West Cross St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lenora S. Butler

(a) Residence No. 133 West Cross St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 7 1849

7-AGE. 75 yrs. 1 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), A. A Co Md

PARENTS.

10-NAME OF FATHER, Richard Butler

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Rebecca Fossett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). A A Co Md

11- (Informant) Rachel Meyers

(Address) 133 W. Cross

15- ROBERT R. KRAUTER,

Filed 19 Burial Permit Clerk, Registrar.

APR 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1st 19.. to April 26 1924 19..

that I last saw her alive on April 26 1924 19.. 12.30 P. M.

and that death occurred, on the date stated above, at 12.30 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis (Hemiplegia)
Arteriosclerosis

(Duration) yrs. 3½ mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

(Duration) yrs. 3½ mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D

April 27 1924 (Address) 1203 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Md	4/28 1924
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E North

Should be carefully prepared in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86392

CERTIFICATE OF DEATH.

X 174

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Anna Knatz

(a) RESIDENCE NO. Owings Mills, Maryland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. / ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of P. Hoffman Knatz

6 DATE OF BIRTH (month, day, and year) April 6, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	27	-	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife at Home
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Arnold

11 BIRTHPLACE OF FATHER (city or town) Carroll County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie C. Michael

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant P. Hoffman Knatz
(Address) Owings Mills, Md.

15 Filed APR 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st + 2nd degree burns of body.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Probably suicide

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hennessy, M. D.
(Coroner.)

April 26, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 28 1924
UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Betts St

TION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D 86393 HEALTH DEPARTMENT—CITY OF BALTIMORE 91-002 ✓ D 86393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 924 N. Gilmor Street St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine E. Fenge

(a) Residence No. 924 N. Gilmor Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June, 3 1848

7-AGE.	If LESS than 1 day.
75 yrs. 10 mos. 24 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, John Fenge

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine E. Muldner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Henry Fenge

(Address) 1813 St. Paul Street

13- Filed APR 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April, 27 1924

17- I HEREBY CERTIFY, That I attended deceased from March 12 19 24 to Apr 27 19 24

that I last saw h[illegible] alive on Apr 26 19 24

and that death occurred, on the date stated above, at 3.40 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. G. Jones M. D.

4/27, 1924 (Address) 720 N. Monta Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. Apr. 29, 1924

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Bates St

Entire be carefully supplied. Exact statement of OCCUPATION must be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86394

CERTIFICATE OF DEATH.

57

D 86394

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1012 Forrest St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Ella P. Kerlerg

(a) Residence No.... 1012 Forrest St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 18 1864

7-AGE, 60 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House work

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Daniel Kerlerg

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Kirlerg

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Ireland

14- (Informant) Mary A. Kerlerg

(Address) 1012 S. Forrest St.

15- [illegible] ROBERT R. KRAUTER, Burial Permit Clerk.

APR 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 1915 to April 26 1924

that I last saw her alive on April 26 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope + Urinalysis

(Signed) M. F. Vaughan M. D.

4-27-1924 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, April 30 1924

20-UNDERTAKER, H. C. Windfield — ADDRESS 4 Fremont Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86395

CERTIFICATE OF DEATH.

74-081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 N Broadway ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Morse

(a) RESIDENCE NO. 418 N Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Morse

6 DATE OF BIRTH (month, day, and year) Oct 5th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Locust Grove Md.
(State or country)

PARENTS

10 NAME OF FATHER Zickarl Anderson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Deleware

12 MAIDEN NAME OF MOTHER Susanna Roberts

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Deleware

14 Informant John Morse
(Address) 418 N Broadway

15 Robert P. Harrison, Registrar
Burial Permit Clerk.

APR 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr. 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from apr 22, 1924, to apr 27, 1924, that I last saw h[illegible] alive on apr 26, 1924, and that death occurred, on the date stated above, at 6:45 A m.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H G Jones M. D.

4/27. 1924 (Address) 720 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Betterton, Kent Co. Md.	4-29-24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N Broadway

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86396

CERTIFICATE OF DEATH. 4 x 90

D 86396

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr J. Thomas Ward. Thomas J. Ward

(a) RESIDENCE NO. Ruxton Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 60 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Ward 1843

6 DATE OF BIRTH (month, day, and year) October 18 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	October		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath - Md -

PARENTS

10 NAME OF FATHER William Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Rebecca Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rebecca Ward

(Address) Ruxton Md

Robert T. Harrison

Registrar

R 28 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17

I HEREBY CERTIFY, That I attended deceased from 4-19, 1924, to 4-27, 1924,

that I last saw h~~i~~m alive on 4-27, 1924,

and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 10 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) prostatic hypertrophy

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4-23-24

Was there an autopsy? no.

What test confirmed diagnosis? Operative finding

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	4-29 1924
20 UNDERTAKER	ADDRESS
Amos M. Jenkins Sons Co.	Orchard & Eutaw

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE or CONDITION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86397

118-00 1V

D 86397

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 102 N. Hare St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella J. Ritzinus

(a) Residence No. 102 N. Hare st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Ritzinus

6-DATE OF BIRTH (month, day and year) Feb. 21-1848

7-AGE. 76 yrs. 2 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Wm. Seymour

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ella Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14 (Informant) Mr. J. Ritzinus

(Address) 102 N. Hare

15-

Filed ..... 192 ..... Registrar.

APR 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 26 24

17- I HEREBY CERTIFY, That I attended deceased from Apr 23 1924 to Apr 26 1924

that I last saw h. Alive on Apr 26 1924

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cancer Strangulated Hernia

(Duration) 5 yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) B. Kelly M. D

Apr 27 1924 (Address) 1001 N Arlington Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: 4/29, 1924

20-UNDERTAKER: J. Frew McCully — ADDRESS: 130 E. Fay

SUDDEN DEATHS should be carefully investigated. Exact statement of OCCUPATION is very important. Physicians are requested to write carefully and in plain terms, so that it may be properly classified. Do not use abbreviations or ditto marks. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86398

CERTIFICATE OF DEATH.

D 86398

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 13 west 25th St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Sheehan

(a) Residence No. 13 West 25th St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Sheehan

6-DATE OF BIRTH (month, day and year)

7-AGE,	If LESS than 1 day,
39 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Lisbon, Md

PARENTS.

10-NAME OF FATHER, James Connaughton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Foley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

11- (Informant) Mrs. Sheehan

(Address) 2427 Kloman Ave

13- Filed APR 28 1924 19? Robert P. Harrison Registrar.

Buried Parish Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 27/24

17- I HEREBY CERTIFY, That I attended deceased from Oct, 1919 to Apr. 27, 1924.

that I last saw h.. alive on Apr 26 1924

and that death occurred, on the date stated above, at 12.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) See above

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. Bacilli in Sputum

(Signed) H. G. Santos, M. D.

, 19 (Address) 634 Gorsuch Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Catholic Cem	Apl 30, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Meaux	502 E. Baltimore

Should be entered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86399
16823

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 36-004 ✓ D 86399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Joseph Jaffee

(a) RESIDENCE NO. Selma Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) dry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Isaac Jaffee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Rachel Paletz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 28 1924 19.. Registrar Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1923 to April 28, 1924.

that I last saw him alive on April 28, 1924,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis kidneys. bilateral

(duration) 4 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Perinephritic abscess

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ala.

Did an operation precede death? yes. Date of 2-18-24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mitchell Wilson M. D.

4/V 1924 (Address) Johns Hopkins Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Camden N. J.

DATE OF BURIAL 4/28 1924

20 UNDERTAKER Col Linnon & Bro

ADDRESS 1127 E Balto St

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86400

D 86400

CERTIFICATE OF DEATH.

REGISTERED NO. 10001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hospital ST., 19 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Stewart

(a) RESIDENCE NO. 222 N Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Evelyn Page
(Address) 936 N. Gilmor

15 Filed R 28 1924 192 Robert P. Harrison, Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

(Signed) Geo E Pleas, M. D.

(Coroner)

192 (Address) 1437 N Amer

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	R 28 1924
20 UNDERTAKER Sam'l W. Chase Son	ADDRESS 1400 Mosher

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36401

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 523 N. Gilmor ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Russell Hawkins

(a) RESIDENCE No. 523 N. Gilmor ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 21 - 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Casey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hattie Hawkins (Address) 523 N. Gilmor

15 Filed ..... 19 ..... Registrar

Burial Permit Given.

PR 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to ..... 19 .....

that I last saw him alive on April 26, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Primary (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Croup (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. J. Coleman M. D.

(Address) 2039 N. Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Apr 29 1924

20 UNDERTAKER Sam'l W. Chase Son — ADDRESS 1408 Maker

mation should be carefully supplied. Also the
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86402

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86402

CERTIFICATE OF DEATH.

122-00

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1839 Guilford Ave. ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William O'Lasagny

(a) RESIDENCE. NO. 1839 Guilford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shot Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

084

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dennis Lasagy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Colyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Margaret Lasagy

(Address) 1839 Guilford Ave.

15 Received APR 28 1924, 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March 2 1924, to April 26, 1924, that I last saw him alive on April 25, 1924, and that death occurred, on the date stated above, at 1230 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Hypertrophic of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) V. Ray Williams, M. D.

, 19 (Address) 901 Cathedral Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Catholic Cemetery — DATE OF BURIAL: 4/27/24

20 UNDERTAKER: C. J. Fanning Nov-1938 — ADDRESS: E. Lafayette Ave.

Burial Permit Work.

mation should be carefully supplied. Exact statement of ... may be properly classified. Exact statement of ... it may be properly classified, so that it ... CAUSE OF DEATH in plain terms, so that it ma... TION is very important. See instructions on bac... back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

George Liang

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86403

23 D 86403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp't ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kang

(a) RESIDENCE NO. 713 Penn St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Dec. 28, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Jos Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Eibly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs George Lang

(Address): 713 Penn St

15 Filed ....., 19 ..... Registrar

Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4.27.1924

17 I HEREBY CERTIFY, That I attended deceased from 4.5.24, 19..... to 4.27.24, 19.....

that I last saw h alive on 4.27.24, 19.....

and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis Encephalitis.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. 1 wk mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Md Gen Hosp't

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon P K Cemetery

DATE OF BURIAL: 4/30/24

20 UNDERTAKER: Geo Leimbach & Son

ADDRESS: 647 W Pratt st.

APR 28 1924 Burial Permit Clerk

mation should be carefully supplied. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

JOHNSON

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86404

D 86404

CERTIFICATE OF DEATH.

REGISTERED NO. 4 + 86

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Clinic Hosp. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Johnson

(a) RESIDENCE NO. Edmondson Ave. ST., WARD Colored Ind.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child NW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas E. Johnson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Effie Cooper

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mother
(Address)

15 Robert J. Harrison, , 19 Registrar

R 2 8 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 28 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 19 24, to 4/28, 19 24,

that I last saw h alive on 4/28, 19 24,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Abscess

Cerebritis

Otitis media

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac failure & pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lynnwood Ind.

Did an operation precede death? No Date of 3/29/24

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) John M. Edmonds, M. D.

, 19 (Address) Penn. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md

DATE OF BURIAL 4-29-24

20 UNDERTAKER Daniel Easton

ADDRESS Bay ave

mation should be carefully supplied. Exact statement of occ
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86405

CERTIFICATE OF DEATH.

74-006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Poplar St. Curtis Bay ST. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Dennis Duvall

(a) RESIDENCE. No. 122 Poplar St. Curtis Bay WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Duvall

6 DATE OF BIRTH (month, day, and year) April 26 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Ind. Alcohol Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savage Maryland

PARENTS

10 NAME OF FATHER Wm. P. Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savage Maryland

12 MAIDEN NAME OF MOTHER Mary Ann Whitesides

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Savage Maryland

14 Informant (Address) Louis Duvall 22 Poplar St. C. B.

15 Filed Robert F. Harrison, Registrar

R 2 8 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to April 26, 1924, that I last saw him alive on April 25, 1924, and that death occurred, on the date stated above, at 3.25 P.M.

The CAUSE OF DEATH* was as follows:

(a) Nephritis

(b) Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 2 days

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Thos. C. Horton M. D.

(Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetary	4/29/24

20 UNDERTAKER Margaret G. Heyman

ADDRESS Baltimore Md.

mation should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86406

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Patterson Park Ave. ST.; 8 WARD)

2-FULL NAME Lillian E. Heyman

(a) RESIDENCE. NO. 1917 Patterson Park Ave. ST.; ..... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) July 29/1923

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	—	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Child. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Lawo T. Heyman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Florence M. Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Florence Heyman (Address) 1917 N. Patterson Park Ave

15 April 29, 1924 Robert P. Harrison, Registrar

PR 28 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924 to April 27, 1924

that I last saw her alive on April 26, 1924

and that death occurred, on the date stated above, at 7 25 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Eczema of scalp

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Albert L. Hesser, M. D.

April 29 1924 (Address) 1211 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 29 1924
20 UNDERTAKER	ADDRESS
Geo. F. Rudo	1735 Hayward

I CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be carefully supplied. Abbreviations may be used in certificates.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86407

D 86407

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

*1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pennington Ave Exh ST., 25 WARD)

2-FULL NAME Isaac E Stewart Sr

(a) RESIDENCE NO. Pennington Ave Exh ST., 25 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Stewart

6 DATE OF BIRTH (month, day, and year) Jan 14 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself 045

9 BIRTHPLACE (city or town) Annapolis
(State or country) Md

PARENTS

10 NAME OF FATHER John M Stewart

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs Isaac E Stewart
(Address) Pennington Ave Exh

15 Filed Robert F. [illegible] Registrar

R 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to April 27, 1924.

That I last saw h[illegible] alive on April 26, 1924

and that death occurred, on the date stated above, at 9-30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of the heart

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) D. L. McKeffen, M. D.

April 27, 1924 (Address) 2321 Dbl Bch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Apr 29 1924

20 UNDERTAKER Wm J. Tickner & Son

ADDRESS N. Va Pa

Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Knetschke, 1025 Madison Ave ✓

D 86408

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 86408

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1027 Madison Ave St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Jeannette E Doyle

(a) Residence No. 1027 Madison ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred E Doyle

6-DATE OF BIRTH (month, day and year) Jan 20, 1855

7-AGE.	If LESS than 1 day,
69 yrs. 3 mos. 6 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer). 13?

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER. Alexander Russell

11-BIRTHPLACE OF FATHER (city or town). Baltimore (State or Country), Md

12-MAIDEN NAME OF MOTHER. Annie J Paul

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), New Jersey.

14- (Informant) Alfred E Doyle

(Address) 1027 Madison Ave.

15- Robert D. Harrison, Registrar.

PR 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 26. 1924.

17- I HEREBY CERTIFY, That I attended deceased from Apr 2, 1909, to Apr 26, 1924, that I last saw h[illegible] alive on Apr 26, 1924, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma involving common duct (Probably 1st primary) to liver

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus → 5yrs+

Bronchopneumonia →

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Microscopical examination

(Signed) Jno A Snider, M. D.

, 19 (Address) 1025 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon	Apr 29, 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 E Fayette ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86409

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 1633 Clifview Av 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Leid

(a) Residence No. 1633 Clifview St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Leid

6-DATE OF BIRTH (month, day and year) Nov 24

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Raymon

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Charles W. Doll

(Address) 1633 Clifview Av

15- [illegible], 192.. Registrar.

~~Burial Permit Clerk.~~

APR 28 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27-1924

17- I HEREBY CERTIFY, That I attended deceased from April, 1924, to April 27, 1924, that I last saw h~~er~~ alive on April 27, 1924, and that death occurred, on the date stated above, at 9 PM.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculo Bacillus

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) O B Carman, M. D.

4-27, 1924 (Address) 1701 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oakhill — DATE OF BURIAL, 4/29, 1924

20-UNDERTAKER. Williams Cook — ADDRESS 502 E North Av

Should be carefully prepared. Exact statement of OCCUPATION is required. Use only such terms as are in common use in plain terms, so that it may be properly classified. Entries should be legibly written in ink. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1325 Sargeant St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Yeakel

(a) Residence No. 1335 Sargeant St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W.	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Henry Yeakel

6-DATE OF BIRTH (month, day and year) Sept 6, 1897

7-AGE, 27 yrs. — mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER George Goth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary Roath

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Henry Yeakel

(Address) 1335 Sargeant St

15- Robert P. Harrison, M.D. 192 Registrar.

APR 28 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-28-24

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 28, 1924, that I last saw her alive on April 28, 1924, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edgar E. Travers, M. D.

, 19 (Address) 1503 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Western	April 1924
20-UNDERTAKER, Wm. Cook	ADDRESS 502 S. Ann St.

In plain terms, so that it may be properly classified. Exact statement of cause of death required. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8641 E

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8641 E

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1916 E. Fairmount Ave Ward) St.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F Shreck

(a) Residence No. 1915 E. Fairmount St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Shreck

6-DATE OF BIRTH (month, day and year) Aug 14-1849

7-AGE. 74 yrs. 8 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm F Shreck

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Belle Pate

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Thomas Shreck

(Address) 1917 N Bradford

15- Robert P. [illegible] Registrar.

APR 28 1924

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27-24

17- I HEREBY CERTIFY, That I attended deceased from April 24 19 24 to April 27 19 24

that I last saw h... alive on April 26 19 24

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows: Cerebral Sclerosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lewis M. D

4/28 19 24 (Address) 413 Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel — DATE OF BURIAL. April 29 19 24

20-UNDERTAKER, Jno. Cook — ADDRESS 502 E Lombard

Should be carefully written in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is required. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86412

CERTIFICATE OF DEATH.

D 86412

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Durham St. ST., 6 WARD)

2-FULL NAME James Landon

(a) RESIDENCE No 228 N. Durham St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Widower.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of None.

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	58.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westmoreland Co. Va

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unkown.

12 MAIDEN NAME OF MOTHER Mary Opery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westmoreland Co. Va

14 Informant Annie Ranson
(Address) 228 N. Durham St

15 Filed ..... 19 ..... Registrar

APR 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27th 1924

17 I HEREBY CERTIFY, That I attended deceased from (about) Jan. 1923 to April 27 1924.

that I last saw him alive on April 26 1924.

and that death occurred, on the date stated above, at 4 50 a.m.

The CAUSE OF DEATH* was as follows:

Arteris Sclerosis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. T. Rocker, M. D.

19 (Address) 1904 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	April 29 1924
20 UNDERTAKER Milton Davis 315	ADDRESS Vr Eden St

mation should be carefully supplied. ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86413

D 86413

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 lincoln court ST., 6 WARD)

2-FULL NAME Elizabeth. Brown.

(a) RESIDENCE NO. 2006 lincoln court. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, ~~HUSBAND~~ (or) WIFE of: William Brown.

6 DATE OF BIRTH (month, day, and year): 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): George Queen 2004 Lincoln ct.

15 APR 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1923. to April 27. 1924.

that I last saw her alive on April 24. 1924.

and that death occurred, on the date stated above, at 10 40 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary): Acute Dilatation

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. T. Rozier M. D.

, 19 (Address) 1204 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery april — DATE OF BURIAL: 30 1924

20 UNDERTAKER: Milton Davis — ADDRESS: 315 N Eden St

mation should be carefully supplied. Exact statement of OCCUPA-
it may be properly classified.
n back of certificates.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86414 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86414

74-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 138 N. Curley St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Strohecker

(a) Residence No. 138 N. Curley St., 6 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced ~~HUSBAND of (or)~~ WIFE of: Late Bernard Strohecker

6-DATE OF BIRTH (month, day and year): Oct. 19th 1857

7-AGE: 66 yrs. 6 mos. 6 ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany.

PARENTS.
10-NAME OF FATHER: George J Zirl
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Dont Know.
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-INFORMANT: Barbara Strohecker
(Address) 138 N. Curley St.

15-

APR 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 25th 1924

17- I HEREBY CERTIFY, That I attended deceased from FEB 28 1924 to April 25 1924
that I last saw h. ER alive on April 25 1924
and that death occurred, on the date stated above, at 4.33 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma after
Paralysis of bladder

(Duration) X yrs. X mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) X yrs. 2 mos. X ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No X

What test confirmed diagnosis? None

(Signed) A. H. Decker M. D

Apr 28 1924 (Address) 928 E North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — DATE OF BURIAL: April 29th 1924

20-UNDERTAKER: Lilly & Zeiler — ADDRESS: 400 S. Wolfe St

Should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86415

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 503 S. Chapel St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel James Mills

(a) Residence No. 503 S. Chapel St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 13th 1877

7-AGE: 46 yrs. 5 mos. 13 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Employed at Mo

(b) General nature of industry, business, or establishment in which employed (or employer): Amer. Can Co

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Henry A. Mills

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Mary E. Norton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto. Md.

14- (Informant): Thomas A. Mills

(Address): 503 S. Chapel St.

15 APR 29 1924 ROBERT P. KRAUTER Registrar. Stewart & Bowen Co. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 26th 24

17- I HEREBY CERTIFY, That I attended deceased from April 24 1924 to April 26 1924

that I last saw him alive on April 26 1924

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Adhesions

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Hess M.D. M. D

April 28 1924 (Address) 1305 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel Cemetery	Apr 29 1924
20-UNDERTAKER.	ADDRESS
Lilly-Zeiler	403 S. Wolfe St

Exact statement of OCCUPATION is necessary. Unless the cause of death is in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86416

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Vessels

(a) Residence No. 724 Grindale Ct St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE, 51 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, John Vessel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

11- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192.... ROBERT R. KRAUTER, Registrar.

APR 29 1924 Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-24-24

17- I HEREBY CERTIFY, That I attended deceased from 4-23, 1924 to 4-24, 1924

that I last saw her alive on 4-24, 1924

and that death occurred, on the date stated above, at 9:45 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension; Myocardial degeneration

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude 9 Hurst M. D.

4-25 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	April 29 1924

20-UNDERTAKER.	ADDRESS
L. E. Brown & Son	108 N. Monta-

Exact statement of OCCUPATION is very important. Should be carefully supplied, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86417. HEALTH DEPARTMENT—CITY OF BALTIMORE. D 86417.

CERTIFICATE OF DEATH. 31 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 S. Clinton St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daisy M. Johnson

(a) Residence No. 206 S. Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11yrs. mos. ds How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Johnson

6-DATE OF BIRTH (month, day and year) June 1898

7-AGE. 35 yrs. 10 mos. ds.

If LESS than 1 day. ....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. George Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. William Ann Larmore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland.

14- (Informant) Edward Johnson.

(Address) 206 S. Clinton St.

APR 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

Dr. Frazer.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/27/24

17- I HEREBY CERTIFY, That I attended deceased from Apr 22, 1924, to 4-27, 1924, that I last saw her alive on 4-26, 1924, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pul TB

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (CHB)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. J. Frazer M. D.

4/28, 1924 (Address) 1939 Mc Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Law Cemetery DATE OF BURIAL. Apr. 29, 1924.

20-UNDERTAKER. John A. Moran ADDRESS 3000 E. Balto St.

Exact statement of OCCUPATION is very important. Should be carefully considered, so that it may be properly classified. Write in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH are necessary. Write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86418

CERTIFICATE OF DEATH.

D 86418

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Presstman ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jane Trustin

(a) RESIDENCE. NO. 539 Presstman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Henry Simpson

6 DATE OF BIRTH (month, day, and year) July 8, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teacher Wife of School Director
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Anne Arundel Co. School Board

9 BIRTHPLACE (city or town) & (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elijah Anderson

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Williams

13 BIRTHPLACE OF MOTHER (city or town) Troppe (State or country) Maryland

14 Informant Stephen H. Trustin
(Address) 539 Presstman St

Filed APR 29 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to April 26, 1924, that I last saw h[illegible] alive on April 25, 1924, and that death occurred, on the date stated above, at 5.50 A. m.

The CAUSE OF DEATH* was as follows:

1 Hemiplegia (duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Physical

(Signed) Milton Wright, M. D.

April 26 1924 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: April 29 1924

UNDERTAKER: Frank Wensley ADDRESS: W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Use abbreviations only if necessary. Fill in all items. Be sure statement is complete and correct. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86419

CERTIFICATE OF DEATH.

31 D 86419

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Carey ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Dandridge.

(a) RESIDENCE No. 1025 Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Jenette Dandridge

6 DATE OF BIRTH (month, day, and year) Sept. 24, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ex-Soldier

(b) General nature of industry, business, or establishment in which employed (or employer) has been sick ever since his discharge and unable to work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fredericksburg, Va.

PARENTS

10 NAME OF FATHER Mitchel Dandridge.

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Gillis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredericksburg va.

14 Informant (Address) Undertaker 1303 Pressman St

APR 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to April 25, 1924, that I last saw him alive on April 25, 1924, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary phthysis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exposure while in the army

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In army in Europe

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) Hamp A. Saunders, M. D.

, 19 (Address) 1133 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Cemetery Washington. D. C.

DATE OF BURIAL April 29 1924

20 UNDERTAKER Mrs Geo. H. Dennis

ADDRESS 1303 Pressman St.

mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86420

CERTIFICATE OF DEATH.

49 D 86420

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Home for Incurables 2100 E. Baltimore St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Saphia Lasinzky

(a) Residence No. 2219 E. Fairmount Ave., St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. 18 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benjaman Lasinzky

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
48 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Russia

PARENTS.

10-NAME OF FATHER, Sam Lasinzky

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country). Russia

12-MAIDEN NAME OF MOTHER, Jennie -------

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Russia

14- (Informant)..... J. Lewis
(Address)..... 1439 E. Balto. St.,

15- APR 29 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 28. 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar. 14 1924 to April 28 1924

that I last saw h.. alive on April 28 1924,

and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stom.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sam'l Lebt-house M. D

. 19 (Address) 1810 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Returned Washington D.C. DATE OF BURIAL. 4/29 1924

20-UNDERTAKER, Jacob Lewis ADDRESS 1439 E Balto St

Physician to carefully supply all items. Exact statement of OCCUPATION is very important. Should be carefully classified. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

See Affadavit on file May 31st 1924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8642I

CERTIFICATE OF DEATH.

90 D 8642I

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew aged Home St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Masha Stolerman

(a) Residence No. 115 Aisquith St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
F	W	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of late Louis Stolerman

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. ~~80~~ yrs. ~~mos.~~ ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Old age
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.
10-NAME OF FATHER. Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia
12-MAIDEN NAME OF MOTHER. Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jack Lewis
(Address) 1439 E Balto St

15- Filed APR 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/28/24

17- I HEREBY CERTIFY, That I attended deceased from April 25 19 24 to April 28 19 24
that I last saw h.. alive on April 27 19 24
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(Duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Oedema
(Duration) 1 yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Wm. F. Baughman, M. D
4/28, 1924 (Address) 730 Aisquith St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Hebrew Cem. DATE OF BURIAL. 4/29 19 24

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto St

Should be carefully examined in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86422

CERTIFICATE OF DEATH.

44 D 86422

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Benjamin

(a) RESIDENCE NO. 2200 Fallow Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Benjamin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 Etsalls St

15 Filed APR 29 1924 19.. ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to April 28, 1924, that I last saw him alive on April 28, 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with metastases to Lung-

(duration) yrs. 3½ mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Isidor M. Fry M. D.

Apr. 29, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave — DATE OF BURIAL 4/29 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Etsalls

mation should be carefully supplied. AGE should be stated in years. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86423

D 86423

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 S. Gilmor ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE NO. 512 S Gilmor ST., 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married,~~ Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Mar 10 - 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Michael Gado

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. A. Johnson

(Address) 1949 W. Lexington St

15 Filed APR 29 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17

I HEREBY CERTIFY, That I attended deceased from May, 1923, to April 27, 1924, that I last saw h alive on April 27, 1924, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Walter E Tuckman, M. D.

4/28, 1924 (Address) 2002 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL April 30 1924

20 UNDERTAKER John J Fedder — ADDRESS 1200 W Lombard

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that i
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86424

129 D 86424

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S Spring ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John William Franklin

(a) RESIDENCE. NO. 215 S Spring ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dr Fisher

(Address) 243 S Spring

15 APR 29 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1924, to Apr 27, 1924, that I last saw him alive on Apr 27, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns, M. D.

4-28-24, 19 (Address) 2017 E 33

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury

DATE OF BURIAL: April 28 1924

20 UNDERTAKER: John W Henderson

ADDRESS 1502 E Monument

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86425

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1206 W. Fayett St., 18 Ward)

Registered No. 161-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Landis Morris

(a) Residence No. 1206 W. Fayett St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 18, 1924

7-AGE, ...yrs...mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER Hugh L. Morris

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Clinton See

12-MAIDEN NAME OF MOTHER Sarah A. Landis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Phila Pa

14-INFORMANT H. L. Morris

(Address) 1206 W. Fayette St

APR 29 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 18, 19 24, to April 27, 19 24,

that I last saw him alive on April 26, 19 24,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Harry Glassman, M. D.

April 27 1924 (Address) 2685 Wiesenlane

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL, Apr 29 19 24

UNDERTAKER: Harry Hlwitz — ADDRESS: 153 W. Lombard St

Should be carefully supplied. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. Instructions on back of certificates.

D 86426 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D 86426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 285 W. 31 St ..... St., 17 ..... Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L. Beane

(Residence in Baltimore: No. Lancaster Co Va ..... St.; yrs., ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Nov 25 (Month) (Day) 187 (Year)

7-AGE. 52 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Do

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Warner W Beane

11-BIRTHPLACE OF FATHER. (State or Country). Va

12-MAIDEN NAME OF MOTHER. Mollie Webb

13-BIRTHPLACE OF MOTHER. (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George L Dunaway

(Address) 285 W 31 st

15- APR 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 28 (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Morrison M. D. (Coroner.)

April 29 1924 (Address) 1632 Riverside Dr

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Emery Point Va — DATE OF BURIAL. Apl 30 1924

20-UNDERTAKER CHENOWETH & SON — ADDRESS 3617 CHESTNUT AVE.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86427.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86427

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3324 Chestnut Ave 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John E. McFall

(a) Residence No. 3324 Chestnut Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Daniel Mc Fall

6-DATE OF BIRTH (month, day and year) March 21 1868

7-AGE. 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of Industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Geo Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-

(Informant). Daniel Mc Fall

(Address). 3324 Chestnut Ave

APR 29 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 26 1924

17- I HEREBY CERTIFY, That I attended deceased from March 8, 1924, to April 26 1924, that I last saw h.e alive on April 26, 1924, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY.....

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E J Barnes M. D.

4-28, 1924 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Hampden

DATE OF BURIAL. Apl 30 1924

20-UNDERTAKER. CHENOWETH & SON,

ADDRESS 3617 CHESTNUT AVE.

Blanks to be carefully filled. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Survey)

D 86428 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86428

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1305 Division ST., 17 WARD)

2-FULL NAME Virginia Penny.

(a) RESIDENCE NO. 305 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Penny

6 DATE OF BIRTH (month, day, and year) July 12-1884

7 AGE 39 Years 9 Months 15 Days | If LESS than 1 day, ...hrs. or .....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Penny (Address) 1305 Division ST. BALTIMORE

15 Filed APR 29 1924 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1924, to Apr. 27, 1924, that I last saw her alive on Apr. 27, 1924, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Abscess

(duration) yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Wm. J. Carr, Jr. M. D.

(Address) 5/5 Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Antum Comty | DATE OF BURIAL 5-1 1924

20 UNDERTAKER George T. A. Gibson | ADDRESS 1735 Druid Hill Ave

N.B. Information should be carefully supplied. AGE should be stated correctly. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86429 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86429

146

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Araminta Jackson

(a) RESIDENCE NO. 210 E Federal ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced
~~HUSBAND OF~~ (or) WIFE of Henry Jackson

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	42	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lydia Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hospital.

15 Filed APR 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 5 , 1924 , to April 27 , 1924 ,
that I last saw her alive on April 27 , 1924 ,
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

tb pyemia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 13, 1924

Was there an autopsy? yes

What test confirmed diagnosis? (autopsy) peritonitis + abscess tbd

(Signed) Susan P. Souther, M. D.

4/28 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gordonsville Va.

DATE OF BURIAL 4/29/24

20 UNDERTAKER Geo. T. A. Gibson

ADDRESS 1735 Druid Hill

N.B. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

William S. Heiss

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86430

CERTIFICATE OF DEATH.

90 D 86430

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Way to Hospital ST., 8 WARD)

University

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. S. Heiss

(a) RESIDENCE NO 2425 E. Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work C. Rapper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gas Light Co

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Fred Heiss

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER A. Bonnde

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant May A. Heiss
(Address) 2425 E Biddle

APR 29 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease from Infancy

(duration) Don't Know yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ... yrs. ... mos. ... ds.

(Signed) T. K. Krauter (Coroner.), M. D.

4-28, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 9-30 1924

20 UNDERTAKER John Ulrich

ADDRESS 200 E Eager

CAUSE OF DEATH must be plainly written, and should be signed by the physician making the certificate. TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86431

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86431

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Calhoun and Fayette Streets. Registered No.....

City of BALTIMORE: (No. Franklin Square Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Charles Ernest Stoffregen

(a) Residence No. 1116 North Fremont Ave? St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Stoffregen

6-DATE OF BIRTH (month, day and year) Oct. 24" 1885

7-AGE, 38 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Barber

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... Self.

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER Charles J. Stoffregen

11-BIRTHPLACE OF FATHER (city or town)..... Baltimore
(State or Country)..... Maryland

12-MAIDEN NAME OF MOTHER, Lillian Thomas

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore
(State or Country)..... Maryland

14- (Informant) Mrs. Mary F. Stoffregen

(Address) 1116 N. Fremont Ave.

APR 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27th 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1924, to Apr. 27, 19 24 that I last saw h. alive on Apr. 27, 19 24 and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 1 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) C. Wheeler Graham, M. D.

4/28, 1924 (Address) Mapleton Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Govans Presbyterian — DATE OF BURIAL, April 29 1924

20-UNDERTAKER, Jas B Cook — ADDRESS 1003 W Baltimore

Exact statement of OCCUPATION is very important. Use should be carefully supplied. All entries should be properly classified. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 86432

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St Joseph's Hosp ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Gettinger

(a) RESIDENCE NO. 2841 Raynor Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER A. C. Gettinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Hedwig Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant A. C. Gettinger

(Address) 2841 Raynor Ave

15 APR 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1924, to April 28, 1924, that I last saw h[illegible] alive on April 28, 1924, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Septic pneumonia
Acute Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute tonsilitis & pharyngitis
Acute appendicitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2841 Raynor Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Evidence

(Signed) Geo B. Dyer, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Bath Cem

DATE OF BURIAL 5/1 1924

20 UNDERTAKER J. Fo McCulley

ADDRESS 130 E. Fort

N. B. [illegible] mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 86433

86433

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓ D 86433

CERTIFICATE OF DEATH

91-002

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2451 McCulloh St ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harrison Ellis

(Residence in Baltimore: No. 2451 McCulloh St.: 74 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6-DATE OF BIRTH: ✓ (Month) ✓ (Day), 1 (Year)

7-AGE: 74 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Va

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or country): Unknown

14-I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Williams

(Address) 2451 McCulloh St

15 APR 29 1924

16-ROBERT F. KRAUSER REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April (Month) 27 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1924, to April 27, 1924, that I saw h— alive on April 26, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Saml Steinberg M. D.

April 27, 1924 (Address) 2302 McCulloh St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Forest Lawn — DATE OF BURIAL: April 29, 1924

20-UNDERTAKER: Theodore W. Pierce — ADDRESS: 113 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

9/Kluga.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86434

CERTIFICATE OF DEATH.

101-006 D 86434

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Kluga

(a) RESIDENCE NO. 1819 Eastern Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1902.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Maks Kluga

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER A. Czajkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Maks Kluga

(Address) 1819 Eastern Ave

APR 29 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28, 1924.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1924, to Apr. 28, 1924, that I last saw him alive on Apr. 27, 1924, and that death occurred, on the date stated above, at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Tuberculosis Pulmonary

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Evidence.

(Signed) Bru Rhodes M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem.

DATE OF BURIAL April 30 1924

20 UNDERTAKER F. N. Ozazewski

ADDRESS 1930 Eastern Ave

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 86435

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 228 Monastery ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James G. Woolfenden

(a) Residence No. 228 Monastery ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Marr'd

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Woolfenden

6-DATE OF BIRTH (month, day and year) Jan. 13, 1884

7-AGE. 40 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bus. Salesman
(b) General nature of industry, business, or establishment in which employed (or employer). Stron M'f'g Co.
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Woolfenden.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bald.

12-MAIDEN NAME OF MOTHER, Ella Nicholson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Margaret Woolfenden
(Address) 228 Monastery ave.

15- APR 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 27-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923 to April 27, 1924 that I last saw h... alive on April 27, 1924 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.

4-29, 1924 (Address) 222 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery.	4/30, 1924

20-UNDERTAKER,	ADDRESS
Geo. J. Ruth.	1735 Harford Ave

Exact statement of OCCUPATION is very important. Should be carefully supplied. Be sure it may be properly classified. Use plain terms, so that instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86436

CERTIFICATE OF DEATH.

31 D 86436

1-PLACE OF DEATH 1507 N. Bertel St

Registered No.....

City of BALTIMORE: (No. 1507 N. Bertel St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Harryman

(a) Residence No. 1507 N. Bertel St St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Florence L. Harryman

6-DATE OF BIRTH (month, day and year) Nov 9 1879

7-AGE.	If LESS than 1 day,
44 yrs. 5 mos. 18 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Insurance Agent

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 07

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles C. Harryman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Sarah E. Poteet

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore Md

14- (Informant) Florence L. Harryman wife

(Address) 1507 N. Bertel St.

15- ROBERT R. KRAUTER,

APR 29 1924 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 1 1923 to April 27 1924

that I last saw him alive on April 27 1924

and that death occurred, on the date stated above, at 12 M. p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Residence of deceased

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Bacteria

(Signed) A. C. MacDonald M. D.

April 28, 1924 (Address) 1540 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	April 30, 1924
20-UNDERTAKER.	ADDRESS
Geo. J. Rueth	1735 Hereford Ave

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

D 86437.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86437.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. George Francis Dodge

(Residence in Baltimore: No. Mercy Hospital St.; yrs., — mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. October (Month) 20 (Day) 1872 (Year)

7-AGE. 51 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Physician
(b) General nature of industry, business, or establishment in which employed (or employer): (Self)

9-BIRTHPLACE, (State or Country). Athol Mass.

PARENTS.

10-NAME OF FATHER. Ezra Preston Dodge

11-BIRTHPLACE OF FATHER, (State or Country) Tamworth N.H.

12-MAIDEN NAME OF MOTHER. Jennie Lind Penniman

13-BIRTHPLACE OF MOTHER, (State or Country) New Hampshire

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Minnie J. Dodge (wife)

(Address) Athol - Mass.

15- Filed APR 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis respiratory Center
Caused by use of
Cocaine & Novocaine Anesthesia
for tooth drug removed.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) M. D. (Coroner)

April 28 192 4 (Address) 1629 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death — yrs. — mos. 1 ds. In the State — yrs. — mos. 1 ds.

Where was disease contracted, if not at place of death? ? ? ? ?

Former or usual residence Athol - Mass.

19-PLACE OF BURIAL OR REMOVAL, Plymouth - N.H. DATE OF BURIAL, Apr 29th 1924

20-UNDERTAKER J. T. & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

CERTIFICATE OF DEATH.

D 86438

D 86438

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Md General Hospital ST., Wb WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Geo Littlefield

(a) RESIDENCE NO. 2905 Belmont Ave ST., 16 WARD Resident

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? 68 yrs. 2 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Virginia Littlefield

6 DATE OF BIRTH (month, day, and year) Feby-6-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	68	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Coffee & Tea

(c) Name of employer C. D. Kenny Co. Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Rufus Littlefield

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Maine

12 MAIDEN NAME OF MOTHER Eugenia McDonald

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) DC.

14 Informant Mrs Alice V. Littlefield (wife)

(Address) 2905 Belmont Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.28.1924

17 I HEREBY CERTIFY, That I attended deceased from 4.26.24 to 4.28.24.

that I last saw h.. alive on 4.28.24, 19....,

and that death occurred, on the date stated above, at 2 20a m.

The CAUSE OF DEATH* was as follows:

Pulmonal Tuberculosis

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senile Cardiac dis

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jno A Thompson, M. D.

, 19 (Address) 1 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL April 30 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE

Information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Jones

D 86439 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 101-00 D 86439

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N. Central ave ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. James

(a) RESIDENCE. NO. 705 N. Central ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1884

7 AGE	Years	Months	If LESS than 1 day hrs. or min.
	40		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen. Carriage Trimmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto and

PARENTS

10 NAME OF FATHER Oliver James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Garnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant J. S. James
(Address) 705 N. Central ave

15 Filed APR 29 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to April 27, 1924

that I last saw h[illegible] alive on April 27, 1924

and that death occurred, on the date stated above, at 6.25 A m.

The CAUSE OF DEATH* was as follows:

Tabes pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

4.28 1924 (Address) 120 Desoto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4/30/24

20 UNDERTAKER ADDRESS R C Gross 1405 McElderry

mation should be carefully supplied. Avoid abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86440

CERTIFICATE OF DEATH.

65-001 D 86440

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., No WARD)

2-FULL NAME Elizabeth House

(a) RESIDENCE NO. 3206 Philadelphia Rd ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H

6 DATE OF BIRTH (month, day, and year) Nov 17/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Conrad Krebs Koltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emily Schrader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 29 1924 ROBERT. R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to April 27, 1924,

that I last saw h-- alive on April 27, 1924,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myeloid leucemia

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood studies

(Signed) Tarussa Aldrich, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 4/30 1924

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans

N. B. ... mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86441 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 86441

CERTIFICATE OF DEATH.

Registered No. 47

1-PLACE OF DEATH

City of BALTIMORE (No. 1712 W. Lafayette Ave, 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Alice Benson

(a) Residence No. 1712 W. Lafayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 16 1841

7-AGE. 82 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). C. A. Co. Md

PARENTS.

10-NAME OF FATHER. Joseph Benson

11-BIRTHPLACE OF FATHER (city or town) (State or Country) A A Co Md

12-MAIDEN NAME OF MOTHER. Mary E. Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14-Informant. Lola G. Stevens

(Address) 1712 W Lafayette Ave

15-Filed Robert P. Harrison, Registrar.

R 2 9 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April-28-24

17-I HEREBY CERTIFY, That I attended deceased from April-21- 1924 to April-28 1924.

that I last saw her alive on April-28- 1924.

and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast
e metastasis of Liver

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marion W Shoaf M. D.

4-28, 1924 (Address) 8067 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem

DATE OF BURIAL. Apr. 30. 1924

20-UNDERTAKER. John O. Mitchell

ADDRESS 1201 W Fayette St

Exact statement of OCCUPATION is very important and should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86442 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86442

CERTIFICATE OF DEATH. X 33

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Snyder.

(a) Residence No. Cokesvill. Howard C Md St., Ward Cockeysville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	W.	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unk- 1853

7-AGE 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Montgomery Co Md

12-MAIDEN NAME OF MOTHER, Katherine Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), " Md.

14- (Informant) Wm Snyder.

(Address) Cokesvill Md

15- Robert P. Harrison, Registrar.

APR 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-29-24

I HEREBY CERTIFY, That I attended deceased from 4-26 1924, to 4-29 1924

that I last saw him alive on 4-29 1924

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Perforation

& Peritonitis.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of bowel

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Goldeen M. D

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL, May 2 1924

20-UNDERTAKER Las P West ADDRESS Cockeysville Md

Should be carefully supplied. Also answer questions in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 86443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86443

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1501 N. Smallwood St. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rochstein

(a) Residence No. 1501 N. Smallwood St. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Rebecca Rochstein

6-DATE OF BIRTH (month, day and year)

7-AGE, 40 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Benjamin Rochstein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Lintzer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balt St

15- Robert P. Harrison, Registrar.

APR 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/29/24

17- I HEREBY CERTIFY, That I attended deceased from April 6, 1924, to April 29, 1924

that I last saw h. alive on April 29, 1924

and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(Duration) Chronic yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 2 hrs

(Duration) yrs. mos.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Mark Bernard M. D.

April 29 1924 (Address) 3 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Wilson Mt Israel

DATE OF BURIAL, 4/29 1924

20-UNDERTAKER, Jack Lewis 1439 E Balt St

ADDRESS

Exact statement of OCCUPATION is Very Important. Space should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86444

D 86444

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1036 N. Calvert ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Turner

(a) RESIDENCE NO. 1036 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Harry F. Turner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Glendy Stuart

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Esibelle Windsor

13 BIRTHPLACE OF MOTHER (city or town) Del
(State or country)

14 Informant Mr Stuart
(Address) Baltimore Md

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

R 29 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1923, to Apr. 28, 1924, that I last saw h~~er~~ alive on Apr. 28, 1924, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1 yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas O. Clarke M. D.

4.29.1924 (Address) Lab. Dept. Chas. & Calvert Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL April 30 1924

20 UNDERTAKER Henry A. Jenkins Son Co.

ADDRESS Orchard & McCulloh

N. B. ... should be carefully supplied. AGE should be stated EXACTLY. Any ... mation should be properly classified. Exact statement of OCC... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86445

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 Hanford Rd ST., Hamilton WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hofstetter

(a) RESIDENCE NO. same ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Hofstetter

6 DATE OF BIRTH (month, day, and year) July 29 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sandyville Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address)

R 2 9 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25 1924 to April 28 1924 that I last saw him alive on April 28 1924 and that death occurred, on the date stated above, at 8.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. W. Bacon M. D.

4/29 1924 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cemetery

DATE OF BURIAL April 29 1924

20 UNDERTAKER Frederick Lissahm Sons

ADDRESS Fullerton

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86446

D 86446

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 76 WARD)

2-FULL NAME Louis Buttenio

(a) RESIDENCE NO Rosedale Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	at School

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	10	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at School
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Buttenio

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Frank Buttenio
(Address) Reisterstown Md.

15 Filed ..... 19.. Robert P. Harrison, Registrar

R 2 9 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Accident

Fracture of Neck

(duration) ..... yrs. ..... mos. 20m ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. 30 ds.

(Signed) Geo Edwin Bland, M. D.
(Coroner.)

4/29/24 (192 (Address) 24 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Rosedale Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL April 30 1924

20 UNDERTAKER Frank Lanahan & Son — ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate.

TION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 86447.

D 86447. 122

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 13 WARD)

2-FULL NAME Mary E. Sipple

(a) RESIDENCE NO. 3734 Falls Road ST., 13 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 9 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Robert E. Sipple

6 DATE OF BIRTH (month, day, and year) July 12-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Glassmyer

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elmira Parsons

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Robert E. Sipple
(Address) 3734 Falls Road.

Filed APR 29 1924 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Duration Hrs. Days

CONTRIBUTORY (Secondary) Arteriosclerosis Duration yrs. Eleven ds.

(Signed) C. M. Kelly (Coroner.), M. D.

April 27, 1924 (Address) 1058 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) 1 Year

At place of death ....yrs., ...mos., ... ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL April 30 1924

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Rd.

Burial Permit filed

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Wheeler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86448 ✓

D 86448

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 564 Orchard St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wheeler

(a) Residence No. 564 Orchard St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, Col | 5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Ada Wheeler

6-DATE OF BIRTH (month, day and year) 1894

7-AGE, ~~30~~ 30 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Draper T. Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, John Wheeler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New York

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Ada Wheeler

(Address) 564 Orchard St

15- Filed Apr 29 1924 Robert P. Harrison, Registrar.

Should be carefully supplied. Exact statement of OCCUPATION is very important. Use words in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 28

17- I HEREBY CERTIFY, That I attended deceased from Apr 26, 1924, to Apr 28, 1924, that I last saw him alive on Apr 28, 1924 and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Consumption (Duration) 6 mos. ds.

* CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? B.C. Examination

(Signed) B.C. Thomas, M. D.

(Address) Apr 29, 1924 1504 E. N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Druid Hill Park Cemetery | DATE OF BURIAL, 4-30, 1924

20-UNDERTAKER, Daniel Easton | ADDRESS 976 Ba ave

Cor.—1-12-23—M&T—100 Bks.

D 86449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 86449

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 N Pobblestown St., 18 WARD)

2-FULL NAME James Brown

(a) RESIDENCE NO 410 N Pobblestown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Dont Know yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colr	Marr'd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Ethel Brown
(Address) 1533 Saratoga St

15 [illegible] 192 Robert P. Harrison, Registrar

APR 29 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner), M. D.

4/29, 1924 (Address) 117 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 192

20 UNDERTAKER Dan'l Easton

ADDRESS 916 6th ave

IMPORTANT is very important. See instructions on back of certificate.

D 86450 HEALTH DEPARTMENT—CITY OF BALTIMORE 188-003 D 86450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. Mercy Hospital St.: 1 WARD) REGISTERED No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev Bernard J. McNamara.

(Residence in Baltimore: No. Sykesville Md. St.; yrs., mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Single

6-DATE OF BIRTH, ..., 1889.
(Month) (Day) (Year)

7-AGE, 35 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... Catholic Priest
(b) General nature of industry, business, or establishment in which employed (or employer)..... 65

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.
10-NAME OF FATHER, Patrick J. McNamara.
11-BIRTHPLACE OF FATHER (State or Country), Ireland.
12-MAIDEN NAME OF MOTHER Catharine McGrath
13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Patrick J. McNamara.
(Address) 328 E. 20th St.

15- Burial Permit Issued ....., 191.....
Robert P. Harrison, Registrar.

APR 29 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr. 28, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract rib & leg
Pulmon. Infarction
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Apr. 29, 1924 (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	May 1, 1924
20-UNDERTAKER	ADDRESS
E A Wedefeld Jr	501 & 22 St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is required to fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Sarah M. Shipley)

D 86451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86451

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (NO. 70 ST., WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M. Shipley

(a) RESIDENCE NO. 1811 W. Mulberry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Abt.	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md

PARENTS

10 NAME OF FATHER Basil Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Amy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records
(Address)

Filed R 2 9 1924, 19

Robert E. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1924 to April 28, 1924

that I last saw her alive on April 28, 1924

and that death occurred, on the date stated above, at 10:54 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma Uteri.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Abstreuenter, M. D.

, 19 (Address) 192 West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 1 1924

20 UNDERTAKER H. J. Tuckner & Sons

ADDRESS 2121 E. Fenna. Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86452 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86452

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, (No. Rogers x Rusk Ave St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret B. Mohr

(a) Residence No. Rogers and Rusk Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Geo. L. Mohr

6-DATE OF BIRTH (month, day and year) Oct 14 1862

7-AGE 61 yrs. 6 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Lehmuth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Holsch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Geo L Mohr

(Address) Rogers & Rusk Ave

15- Robert P. Harrison,

Filed ..... 192..... Registrar.

R 2 91924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 27/24

17- I HEREBY CERTIFY, That I attended deceased from April 19 1924 to April 27 1924

that I last saw her alive on April 27 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) K. C. Metzel M. D

April 28 1924 (Address) 1903 W. Fayette,

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenridge	April 30 192
20-UNDERTAKER. H. H. Lichtenstein	ADDRESS. Walbert Ave

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86453 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86453

CERTIFICATE OF DEATH.

33

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 Birchwood ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Flynn

(a) Residence No. 117 Birchwood St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 6-1888

7-AGE. 35 yrs. 6 mos. 21 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER, James A. Flynn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Margaret Kenny

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ~~Balto~~

14- (Informant) Francis B. Flynn

(Address) 117 Birchwood ave

15- APR 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 27-1924

17- I HEREBY CERTIFY, That I attended deceased from April 7 1924 to April 27 1924

that I last saw him alive on April 27 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Peritonitis

(Duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(Duration) — yrs. 6 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

4/29, 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Catholic Cem. DATE OF BURIAL. April 30 1923

20-UNDERTAKER. F. A. Krauer & Son ADDRESS 703 Hanover St

Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86454

CERTIFICATE OF DEATH.

100-001 D 86454

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Arlington Ave ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa De Pasquale

(Residence in Baltimore: No. 508 N. Arlington Ave St.; 12 yrs., ? mos. ? ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Feb (Month) 22 (Day), 1841 (Year)

7-AGE, 83 yrs. 2 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer)..... —

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, C. Fontini

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Pasquale Not remembered

13-BIRTHPLACE OF MOTHER (State or Country), Italy,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Glunkett

(Address) 508 N Arlington

15- APR 30 1924 1924 ROBERT N. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1919, to Apr 27 1924, that I saw her alive on Apr 27 1924, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-pneumonia, (hypostatic congestion).

(Duration) 0 yrs. 0 mos. 12 ds.

CONTRIBUTORY: (Secondary) Senile Asthenia

(Duration) 4 yrs. 6 mos. 28 ds.

(Signed) John C. Stapleton M. D.

191... (Address) 1037 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral

DATE OF BURIAL, 4/30/24 191...

20-UNDERTAKER J. J. Fahey & Sons

ADDRESS 1318 Light St.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Zollickoffer

(a) RESIDENCE NO. 1146 Carroll st ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 28 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William I. Zollickoffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Jennie Milroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) William I Zollickoffer 1146 Carroll St.

15 APR 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1924, to April 28, 1924,

that I last saw her alive on April 28, 1924,

and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(28th week pregnancy)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical data

(Signed) A A Susman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	April 30 1924
20 UNDERTAKER	ADDRESS
James Dizman & Son	1000 S. Paca St

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 86456
1 PLACE OF DEATH

CERTIFICATE OF DEATH

90 ✓ D 86456
REGISTERED NO. C

CITY OF BALTIMORE (No. 627 S Potomac — St.: — WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredericka Wilde

(Residence in Baltimore: No. 627 S Potomac St. St.: 2 yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: female

4-COLOR OR RACE: white

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): widow

6-DATE OF BIRTH: Dec 22, 1842 (Month) (Day) (Year)

7-AGE: 81 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None -
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Germany -

PARENTS

10-NAME OF FATHER: Jno. Draper

11-BIRTHPLACE OF FATHER (State or country): Germany -

12-MAIDEN NAME OF MOTHER: Dorothy Copenhagen

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Woodfield

(Address) 627 Potomac St

15

APR 30 1924

ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: April 27, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/19, 1924, to 4/27, 1924, that I saw her alive on 4/26, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency -

(Duration) yrs. mos. 8 ds

Contributory (SECONDARY): Chronic Myocarditis

(Duration) yrs. mos. ds.

(Signed) C A Reifschneider M. D.

4/28, 1924 (Address) 2939 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Johns Cemetery Sheph Pk

DATE OF BURIAL: April 30, 1924

20-UNDERTAKER: B L Hopkins

ADDRESS: [illegible]

Spec.—1-10-21—M&T—1500 lbs.

D 86457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 D 86457

1-PLACE OF DEATH University Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

2-FULL NAME Sarah Hooks

(a) RESIDENCE NO. 1505 Franklin ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Blk	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H Wife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm S. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Georgiana Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Hooks

(Address) 1505 Franklin St

15 APR 30 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17

I HEREBY CERTIFY, That I attended deceased from April, 1924, to April 26, 1924.

that I last saw h[illegible] alive on April 26, 1924,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid.

Chronic Salpingitis Bilateral

Pelvic Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative Infection

Psychosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 8

Was there an autopsy? Yes Date of April 19

What test confirmed diagnosis? Clinical & Operative findings

(Signed) [illegible] M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4-30 1924

20 UNDERTAKER John N. Forden

ADDRESS 942 Hanover St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 86458

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 D 86458

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy Gladden

(a) RESIDENCE No. 8 S. 7 Raborg St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) apr 7-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Eugene Gladden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lulu McDonnell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Lucie McDonnell
(Address) 8 S 7 Raborg St

15 Filed APR 30 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.)
thereon and from the evidence obtained by said find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Burns on body

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pellagra a Post mortem

(duration) yrs. mos. ds.

(Signed) W R Jamison, M. D.
(Coroner)

4 30, 192 4 (Address) 117 N Gaston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL apr 30 1924

20 UNDERTAKER John N. Trader — ADDRESS 142 Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86459

101-00 D 86459

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3810 Main Ave ST. 27 WARD)

2-FULL NAME William Franklin Hahn

(a) RESIDENCE. No. 3810 Main Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B. King

6 DATE OF BIRTH (month, day, and year) Nov. 1-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Business

(b) General nature of industry, business, or establishment in which employed (or employer) For Self. 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md

PARENTS

10 NAME OF FATHER Wm Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Alice Morningstar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Emma Hahn (Address) 3810 Maine Ave

15 Filed APR 30 1924 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28 1924

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1924, to April 28, 1924.

that I last saw h... alive on April 27, 1924.

and that death occurred, on the date stated above, at 8:45 Am.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. C. Zimmerman, M. D.

4/29 1924 (Address) 2858 Hayford Rd

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon	April 30, 24

20 UNDERTAKER ADDRESS

Edw. Geo. Gorsuch & Son Edmondson Av

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86460

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86460

CERTIFICATE OF DEATH.

1394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Eagan

(a) RESIDENCE NO. 316 S. Register ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Michael H. Eagan

6 DATE OF BIRTH (month, day, and year) June 29, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Lewis Donnenfelser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Michael H. Eagan

(Address) 316 S. Register St.

15 Filed APR 30 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-15, 1924, to 4-29, 1924, that I last saw h.E.Y. alive on 4-29, 1924, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Post Influenza Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4-17-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic Findings

(Signed) J. Norwood Kerr M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	May. 2 1924
20 UNDERTAKER	**ADDRESS**
Wm Cook	502 E Monument

N. B.—WRITE PLAINLY, with ink, all information supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54-902

D 86461

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. arbuton ave ST., 25 WARD)

2-FULL NAME Earl Price

(a) RESIDENCE NO. arbuton Lakeland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Lakeland
(State or country)

PARENTS

10 NAME OF FATHER Chas A Price

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Florence E. Wolf

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md

14 Informant Florence Price
(Address) Arbuton ave Lakeland

15 Filed APR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 28 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-25, 1924, to 4-27, 1924,

that I last saw h[im] alive on 4-27, 1924,

and that death occurred, on the date stated above, at ..... A. m.

The CAUSE OF DEATH* was as follows:

General debility caused
by fatal attack of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W Hall, M. D.

, 19 (Address) Halethorp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL April 30 1924

20 UNDERTAKER H W Cole — ADDRESS 502 E. A. St.

N. B.—WRITE PLAINLY, with indelible pencil. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86462

D 86462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Mc Culloh St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Walter

(a) RESIDENCE NO. 1103 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Apr. 29, 1924

7 AGE Years Months Days If LESS than 1 day, 1 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Willie Haller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Pearl Eson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U.S.

14 Informant Pearl Haller
(Address) 1103 Mc Culloh St

APR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29. 1924

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1924 to April 29, 1924.

that I last saw her alive on April 28, 1924,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar, about 5 or 6 days duration.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cough & Measles 2 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Miller M. D.

(Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Hosp — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY with ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86463

CERTIFICATE OF DEATH.

90 D 86463

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Chestnut Av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Irene Howard-

(Residence in Baltimore: No. 3603 Chestnut Av St.; 25 yrs., ... mos. ..... ds.)

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	White	Widowed

6-DATE OF BIRTH, April 9th, 1836.
(Month) (Day) (Year)

7-AGE, 87 yrs. 8 mos. 20 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Ulysses Ward

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Susan V. Beall

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... M. D. Howard-M.D.

(Address) 3324 Chestnut Ave

15- APR 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 27 1924, to April 29 1924, that I saw h[illegible] alive on April 29 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) M. M. Howard M. D.

April 30, 1924 (Address) 3324 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Glenwood Cem. Wash D.C. DATE OF BURIAL, May 1, 1924

20-UNDERTAKER A. E. Marshall ADDRESS 3323 Fall Road

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86464

CERTIFICATE OF DEATH.

58-001 ✓ D 86464

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas Little

(a) Residence No. 714 W. 34th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Aug 5-1874

7-AGE. 49 yrs. 8 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Labor

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER. Bethel Little

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER. Williamina Pilmore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Mrs Frank Ludzuck

(Address) 714 W. 34th St

15-

Filed ..... 192.....

(Clerk.)

APR 30 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March 19 24 to April 29 19 24

that I last saw him alive on April 29 19 24

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam-Blood Exam

(Signed) H. V. Harper M. D

19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's N.

DATE OF BURIAL, May 2 19 24

20-UNDERTAKER. A. S. Marshall

ADDRESS 353 Fallsway

Please should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86465 HEALTH DEPARTMENT—CITY OF BALTIMORE

80 D 86465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Longwood ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth May Ahrendt

(a) RESIDENCE NO. 943 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? 1 yrs. 2 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 23/1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Earl H. Ahrendt

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Ida Guth

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Earl H Ahrendt
(Address) 943 Ashburton St

15 FILED APR 30 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1924, to April 29, 1924, that I last saw h[illegible] alive on April 28, 1924, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, dis turbances of stomach — fever

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 2 hrs ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas. H. Burbank, M. D.

(Address) 1100 W. Lafayette Av, April 30, 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL May 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1946 W. North Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86466

CERTIFICATE OF DEATH.

90

REGISTERED NO. D 86466

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1236 Edlings ST., 17 WARD)

2-FULL NAME William Clark

(a) RESIDENCE NO. 1236 Edlings ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Clark

6 DATE OF BIRTH (month, day, and year): October, 1850

7 AGE: Years 74 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coachman

(b) General nature of industry, business, or establishment in which employed (or employer): 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Co. Va. Harford

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mary E. Clarke 1236 Edlings

APR 30 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 26 1924

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1924, to April 26, 1924,

that I last saw h[illegible] alive on April 26, 1924,

and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wheatley, M. D.

4/30, 1924 (Address) 1230 Division Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 4/30 1924

20 UNDERTAKER: Samuel Hawsley

ADDRESS: Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86467. HEALTH DEPARTMENT—CITY OF BALTIMORE D 86467.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3819 Fernwood Ave St. 26 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D. Swisher

(a) RESIDENCE No. 3819 Fernwood Ave St. 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Swisher

6 DATE OF BIRTH (month, day, and year) May 1, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Steelton, Pa.

PARENTS

10 NAME OF FATHER James R. Swisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Altoona, Pa.

12 MAIDEN NAME OF MOTHER Mary A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chambersburg, Pa.

14 Informant James R. Swisher (Address) 3819 Fernwood Ave.

15 APR 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923, to April 27, 1924.

that I last saw him alive on April 27, 1924,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

(duration) ... yrs. 7 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo. J. Lochbuehler, M. D.

, 19 (Address) 806 S. 3d St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	April 30-24
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAME should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86468 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86468

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph E. Norris

(a) RESIDENCE NO. 405 Tyson ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

Filed APR 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-16, 1924, to 4-28, 1924, that I last saw him alive on 4-27, 1924 and that death occurred, on the date stated above, at 7 50 a.m.

The CAUSE OF DEATH* was as follows:

C. N. S Syphilis
(General Paresis)

(duration) ? yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Pruce, M. D.

4-28 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N. Peters Cemetery Apr 1924	
20 UNDERTAKER	ADDRESS
Mac R. E. Elliott	1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86469

CERTIFICATE OF DEATH.

D 86469

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 N. Front St. WARD 5)

2-FULL NAME David Benson

(a) RESIDENCE No. 1047 N. Front St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 101-09

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Oil)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. R. G. Elliott

(Address) 1225 Ashland Ave

15 Filed APR 30 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to April 27, 1924, that I last saw him alive on April 26, 1924, and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Chronic Appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Chas. F. Hall, M. D.

, 19 (Address) 426 E. 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	April 30 1924
20 UNDERTAKER	**ADDRESS**
Mrs. R. G. Elliott	1225 Ashland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86470

CERTIFICATE OF DEATH.

43 D 86470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bert Vernon

(a) RESIDENCE NO. 611 Curtis Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
Abt 44				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn.

PARENTS

10 NAME OF FATHER Edmund Vernon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Mary Houston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Wendell Dipper Sr

(Address) 311 Allen St

15 APR 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1924, to 4-23, 1924, that I last saw him alive on 4-23, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from vessels of neck

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of tongue and glands of neck (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 1-24-24

Was there an autopsy? yes.

What test confirmed diagnosis? Operative findings

(Signed) John M. Edmonds M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 4-25-24

20 UNDERTAKER Wendell Dipper & Son ADDRESS 37 Lond

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

(See Letters file of May 7-1924)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86471 — 3 | D 86471

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No.) 120 N. Luzerne Av. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth DeHaven

(a) Residence No. 120 N. Luzerne Av. St., 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ ~~Married~~ ~~Widowed~~ or ~~Divorced~~, (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel DeHaven

6-DATE OF BIRTH (month, day and year) June 18-1837

7-AGE. 79 10 28 — 86 yrs. 10 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Own home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Phila

PARENTS.

10-NAME OF FATHER. Benj Vollentine

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Vermont.

12-MAIDEN NAME OF MOTHER. Emily Emery.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Dr Late Skinner

(Address) 120 N. Luzerne Av.

15-

Filed ..... 192.....

APR 30 1924

ROBERT R. KRAUTER (Registrar)

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March 20 1924 to April 29 1924

that I last saw h... alive on April 29 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic arthritis & Chronic Bronchitis

(Duration) ....yrs. 1 mos. 9 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis Kolb M. D.

4/30 1924 (Address) 1208 Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	May 2nd 1924
20-UNDERTAKER, Dieterich & Son	ADDRESS 1723 N. Eutaw St.

N. B.—All questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86472

CERTIFICATE OF DEATH.

90 D 86472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1941 N. North Ave St.; 15 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Martha Ann Harman

(Residence in Baltimore: No. 1941 N. North Ave St.; 7 yrs., ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ~~Sept~~ Dec. 30, 1847 (Month) (Day) (Year)

7-AGE, 76 yrs. 4 mos. ✓ ds.

If LESS than 1 day, ✓ hrs. or ✓ min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), York County Pennsylvania

PARENTS.

10-NAME OF FATHER, Israel Danner.

11-BIRTHPLACE OF FATHER (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER Elizabeth Brinn

13-BIRTHPLACE OF MOTHER (State or Country), Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. W. Williams, Jr.

(Address) 1941 N. North Ave

15-

Robert P. Harrison, M.D.

(Address)

APR 30 1924

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 30, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 18 1923, to April 30 1924, that I saw h~~e~~r alive on April 28 1924, and that death occurred, on the date stated above, at 8.40 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ✓ yrs. 6 mos. ✓ ds.

CONTRIBUTORY (Secondary) Senile Debility

(Duration) 7 yrs. ✓ mos. ✓ ds.

(Signed) George C. Shannon M. D.

4/30, 1924 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence -

19-PLACE OF BURIAL OR REMOVAL, Shiffensburg Pa

DATE OF BURIAL, May 1, 1924

20-UNDERTAKER Harry W. Ehlen

ADDRESS 1900 N. North Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Hks.

D 86473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86473

CERTIFICATE OF DEATH.

+179

1-PLACE OF DEATH Died enroute

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Howard Draayer

(a) RESIDENCE No. East Ave Carney Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Dec 15/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Francis J. DRAAYER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co Md

12 MAIDEN NAME OF MOTHER Mary A. Roeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co Md

14 Informant Francis J. Draayer
(Address) Fullerton Md

15 Robert P. Harrison, Registrar
19

R 3 01924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over body-Accident- Fell in tub of hot water.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Potter, M. D. (Coroner.)

Apr 29/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 1st 1924
20 UNDERTAKER Fredk Leadmon Sons	ADDRESS Fullerton

(Information should be carefully supplied. AGE should be stated EXACTLY. ABBREVIATIONS should be avoided. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec– 12-23-21– E.B.P.S.– 400 Blks.

D 86474 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 86474

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hosp. St., 25 Ward) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Allen

(a) Residence No. Marlington, W. Va. St., ... Ward Marlington W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M. | 4-COLOR OR RACE, W. | 5-Single, Married, Widowed, or Divorced, (Write the word.) Unknown

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown 1859

7-AGE, 65 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), W. Va

PARENTS.
10-NAME OF FATHER, Do not know
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Dont Know
12-MAIDEN NAME OF MOTHER, Do not Know
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do not Know

14- (Informant) Geo. Allen
(Address) Marlington W. Va.

15- Filed R 3 01924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 29 - 24

17- I HEREBY CERTIFY, That I attended deceased from April 16 24 to April 29 1924
that I last saw him alive on April 29 1924
and that death occurred, on the date stated above, at 8-55 P. m.

The CAUSE OF DEATH* was as follows:
Post Operative Cerebral Embolism

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Extensive Metastases to Glands of Neck, from Carcinoma of Lip (?)
(Duration) ..... yrs. (?) mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 25, 1924
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) H O Harper, M. D
, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL MARLINTON W.V.A — DATE OF BURIAL, 5/3, 1924

20-UNDERTAKER ROBERT BROOKS & SON — ADDRESS COR CALHOUN HOLLINS ST

FUNERAL DIRECTORS & EMBALMERS
S. E. CORNER CALHOUN & HOLLINS STREETS

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86475

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

2-FULL NAME James M. Behrns

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital
(Address)

15 APR 30 1924 Robert D. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2x 192x

17

I HEREBY CERTIFY, That I attended deceased from 4-18, 192x, to 4-2x, 192x

that I last saw him alive on 4-2x, 192x

and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Myocarditis

Myocardial Insufficiency

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY
(Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ex

(Signed) Claude G. Drane, M. D.

4-24 192 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS APR 30 192

For Wm. R. WOODALL

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86476

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 D 86476

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Found floating in the water

CITY OF BALTIMORE: (No. Foot of Cross Street, ST., 24 WARD).

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Do not know. (Michael Schmidt)

(a) RESIDENCE No. (925 Fell St) Do not know. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---- yrs. ---- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 55		----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 07

(b) General nature of industry, business, or establishment in which employed (or employer) Do not know.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report. S. D.

(Address)

15 Filed APR 30 1924 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

Body found floating April 24, 1924.

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probably Accidental.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

April 29 1924 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
UNIVERSITY OF MARYLAND	
20 UNDERTAKER Commissioner Health.	ADDRESS APR 30 1924

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Re-Moved

Spec.—1-10 21 M&T 1500 Bks.

D 86477. D 86477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mc. Gen Hospt. ST., 19 WARD)

2-FULL NAME Henry Smith

(a) RESIDENCE NO. 1530 W. Lexington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER N.C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER N.C.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Henry Smith
(Address) 1530 W Lexington

15 Filed ..... Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-24

17 I HEREBY CERTIFY, That I attended deceased from 4-26-24 19..., to 4-28-24 19...,
that I last saw him alive on 4-28-24, 19...,
and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

1 Bilateral pneumonia (a)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac fail 1 min

Pulmonary Edema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Sign

(Signed) J. no A Compagnino, M. D.

, 19 (Address) 1530 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND

Spec.—8-24-14—M. & T.—2000 Bks.

D 86478

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 86478

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeth's Home Chesnut Hill Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roche Armstrong

(Residence in Baltimore: No. St. Elizabeth's Home St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	negroe	

6-DATE OF BIRTH. January (Month) 10 (Day), 1924 (Year)

7-AGE. ....yrs. 3 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER Ella Armstrong

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Robert P. Harrison, JOHNS HOPKINS HOSPITAL

APR 30 1924 Burial Permit Clerk..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April (Month) 28 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1924, to April 26 1924, that I saw h im alive on April 26 1924, and that death occurred, on the date stated above, at 11A. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

..... (Duration)...,...yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Frank J. Ayd M. D.

Apr 28, 1924 (Address) 2005 E. Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner of Health, ADDRESS APR 29 1924

Per. Jas. H. [illegible]

Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86479

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-006 ✓ D 86479

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401½ N Vincent ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stenson

(a) RESIDENCE NO. 401½ N Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 4/27/24

7 AGE Years Months Days If LESS than 1 day 18 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Stenson

11 BIRTHPLACE OF FATHER (city or town) Simpsonville (State or country) Howard Co Maryland

12 MAIDEN NAME OF MOTHER Leslie Maddy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mother (Address)

15 Robert F. Harrison, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1924

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to April 27, 1924, that I last saw her alive on April 27, 1924, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Reese, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS

Commissioner Health,

APR 29 192

per Wm. S. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificates.

R 3-01924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86480 185 D 86480

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brigid O'Brien

(a) RESIDENCE NO. St Joseph's Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House 10 07

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Jermiah O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie O'Brien

(Address) 1120 Forrest St.

15 APR 30 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1924, to April 28, 1924.

that I last saw her alive on April 28, 1924,

and that death occurred, on the date stated above, at 11.50 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Cachexia
Hypostatic pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture rt. humerus

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? St. J. H. Surg

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? Usual

(Signed) Geo. B. Rybert, M. D.

, 19 (Address) St. Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral May 1

DATE OF BURIAL 1924

20 UNDERTAKER H. C. Wiedefeld 914

ADDRESS Greenmt Av

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. (3230 Washington Av.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

17038 D 86481

CERTIFICATE OF DEATH.

122-09 D 86481

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. W

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Harry Bowers

(a) RESIDENCE NO. 323 Washington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Peter Bowers

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Anna Peterman

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Robert P. Harrison, M.D. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1924

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1924, to April 25, 1924,

that I last saw him alive on April 25, 1924,

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver, Jaundice

(duration) yrs. 1½ (Asthma) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar 31 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. P. Harrison, M. D.

4/29, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	May 1 1924
20 UNDERTAKER	ADDRESS
Geo M. Fuith & Son	814 N Wolfe

PR 30 1924

Druid Forest Cert.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86482

D 86482

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 160 N. Gay St., 11 Ward)

2-FULL NAME Unknown Male Hopkins

(a) RESIDENCE No. 1122 N Chester St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 53				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mr Kuh

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ella Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Pat Hopkins
(Address) W Hamm Conn,

15 Apr 30 1924 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

Duration (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... , M. D. (Coroner.)

Apr 30 , 1924 (Address) 1039 Bel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic	5/1/1924
20 UNDERTAKER	ADDRESS
E J Manning & Son 1938	E Lafayette

Burial Permit Clerk.

BEFORE SIGNING BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified

Cor.—1-12-23—M&T—100 Bks.

D 86483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86483

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Prev 5- Pratt St 4 ST., ... WARD)

2-FULL NAME "Clark. Clarke" (Full Christian name)

(a) RESIDENCE NO. Lutheran ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Lutheran

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	30	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address) Robert P. Harrison,

15 Filed APR 30 1924 Burial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

accidentally fell
in water

(duration) ..... yrs. ..... mos. about ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Carey, M. D.
(Coroner.)
April 30, 1924 (Address) 1032 Fawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER Wm. P. WOODALL	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Blks.

Dobson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86484

CERTIFICATE OF DEATH.

90 D 86484

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 944 N. Chester St., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dobson

(a) RESIDENCE NO. 944 N. Chester ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND ~~of~~ (or) WIFE of Clara Dobson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Jos. Himself

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Clara Dobson
(Address) 944 N. Chester St.

15 MAY 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30/24

17

I HEREBY CERTIFY, That I attended deceased from 4/22/24, 19..., to 4/29/24, 19...

that I last saw him alive on 4/29/24, 19...

and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows:

Heart Disease

(duration) 1 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alfred Gage M D, M. D.

4/30/24 (Address) 759 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Maryland — DATE OF BURIAL: May 1924

20 UNDERTAKER Wendell & Zeppelin — ADDRESS E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86485

CERTIFICATE OF DEATH.

43 D 86485

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 602 Barre ST., 27 WARD)

2-FULL NAME Frank Cox

(a) RESIDENCE No. 602 Barre ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Cox

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Oil

(b) General nature of Industry, business, or establishment in which employed (or employer) Seamen

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Cox

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Melvina Hard

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Elizabeth Cox (Address) 602 Barre St

15 MAY 1 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15 1924, to April 28 1924, that I last saw h[illegible] alive on April 27 1924, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma Duodenum Glands & Tongue

..... (duration) — 4 mos . ds.

CONTRIBUTORY (Secondary)

..... (duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Jan 1923

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John C Stevens, M. D.

, 19 (Address) 1047 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL May 1, 24

20 UNDERTAKER John N. Trader — ADDRESS 192 Linden Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 86486

CERTIFICATE OF DEATH.

74-001

D 86486

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 Park ave. ST.: | | WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornalia Cook -

(a) RESIDENCE. No. 1105 Park ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of data should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female -	Colored -	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Cook.

6 DATE OF BIRTH (month, day, and year) Dec. 21 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45 -	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Cook, 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland -

PARENTS

10 NAME OF FATHER John Jones -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland -

12 MAIDEN NAME OF MOTHER Rachael Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Maryland -

14 Informant John Cook - Husband (Address) 1105 Park ave.

15 Filed MAY 1 - 1924, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 28th - , 1924, to April 29th - , 1924, that I last saw h.r alive on April 28th - , 1924, and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Cerbral - Haemarhage -

(duration) ....yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) not known -

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Samuel A Baird, M. D.

, 19 (Address) 937 madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon

DATE OF BURIAL: 5-1- 1924

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86487

CERTIFICATE OF DEATH.

38 D 86487

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 N Carlton ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L. Johnson

(a) RESIDENCE No. 104 N Carlton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Cora Johnson

6 DATE OF BIRTH (month, day, and year) Sept 13, 1873

7 AGE: Years 50 Months 7 Days 14

If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Josephine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cora Johnson (Address) 104 N Carlton St

15 Filed MAY 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from Jany 19, 1924, to April 27, 1924, that I last saw him alive on April 27, 1924, and that death occurred, on the date stated above, at 5.45 p m.

The CAUSE OF DEATH* was as follows:

Aneurysm (Abdominal)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. F. Howell M. D.

1924 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 5-1- 1924

20 UNDERTAKER David Easlois

ADDRESS 916 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86488

CERTIFICATE OF DEATH.

129 D 86488

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 605 N. Calvert St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William G. Tuttle

(a) Residence No. 605 N. Calvert St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 23 1884

7-AGE.	If LESS than 1 day,
40 yrs. 2 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer). Ordinary Labor

(c) Name of employer.... At home

9-BIRTHPLACE (city or town)..Baltimore City
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm G Tuttle

11-BIRTHPLACE OF FATHER (city or town)..Balto Md
(State or Country), City

12-MAIDEN NAME OF MOTHER, Brien

13-BIRTHPLACE OF MOTHER (city or town)..Cambridge
(State or Country), Md

14-
(Informant)..Doctor
(Address) 717 E 23rd St

15-
MAY 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 29th 1924

17- I HEREBY CERTIFY, That I attended deceased from March 28th, 1924, to April 29th, 1924, that I last saw him alive on April 28th, 1924, and that death occurred, on the date stated above, at 5.a. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

.....(Duration)....yrs. One mos. One ds.

CONTRIBUTORY (Secondary) Bronchitis & Gastro Enteritis

.....(Duration)..One yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? Home at home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Tests

(Signed) Daniel J. Boyle M. D.

, 19 (Address) 1516 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ..., 19..
Loudon Park	5/1/24
20-UNDERTAKER	ADDRESS
Joseph Fahey	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86489

CERTIFICATE OF DEATH.

438 D 86489

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles W Fritz

(a) RESIDENCE NO. Mount Hope Retreat ST., 28 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Fritz

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt 44		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Watching

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) Carroll Co (State or country) Md.

10 NAME OF FATHER Jacob Fritz

11 BIRTHPLACE OF FATHER (city or town) Frd. Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia Brown

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Penna

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat Md.

15 Filed MAY 1 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 13, 1923 to Apr 29, 1924, that I last saw him alive on Apr 29, 1924, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Paresis - (Luetic)

with Epileptoid Basmus.

abt (duration) 2 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Paretic Psychosis.

abt (duration) 2 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frank Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Md	5/2 1924
20 UNDERTAKER Geo A Tinley	ADDRESS Fulton Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86490 — 100-001 — D 86490

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1127 W Baltimore St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina W. Staib

(a) Residence No. 1127 W Baltimore St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William Staib

6-DATE OF BIRTH (month, day and year) Oct 29 1849

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Duties
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Peter Dasch.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Justina Kuell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) William Staib

(Address) 1127 W. Baltimore St

MAY 1 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29 1924

I HEREBY CERTIFY, That I attended deceased from Feb 24 1924 to Apr 29 1924, that I last saw her alive on April 29 1924, and that death occurred, on the date stated above, at 8:40 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 5 yrs. 2 mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Myocarditis

(Duration) Over 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry E. Hale M. D.

Apr 29 1924 (Address) 1203 W. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	May 1 1924
20-UNDERTAKER.	ADDRESS.
John O. Mitchell	1201 W Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 86491 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86491

101-306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Corning Hse, ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. Lilly

(a) RESIDENCE NO. 1326 W. Saratoga St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Lilly

6 DATE OF BIRTH (month, day, and year) about 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha Lilly
(Address) 1326 W. Saratoga St

15 Date MAY 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

April 29, 1924 (Address) 28 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jefferson, Md.	May 2 1924
20 UNDERTAKER Sam'l. Chase & Son	ADDRESS 1400 Harlem

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86492

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86492

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Woodlawn Rd ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Lumsdon Bond

(a) RESIDENCE NO. 207 Woodlawn Rd ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 79 yrs. 8 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rev. Beverly W. Bond

6 DATE OF BIRTH (month, day, and year) Aug-17-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Anna Frederick Maryland

PARENTS

10 NAME OF FATHER Wm. Ellis Lumsdon

11 BIRTHPLACE OF FATHER (city or town) Alexandria (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Magruder

13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co (State or country) Md

14 Informant Miss Bond (Sister) (Address) Roland Park - City

15 Filed MAY 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to April 29, 1924, that I last saw her alive on April 29, 1924, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Left Hemiplegia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Paralysis

(Signed) M. G. Porter, M. D.

4/30, 1924 (Address) 432 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL May 1, 1924

20 UNDERTAKER STEUART & POWELL COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact s' TION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86493

CERTIFICATE OF DEATH.

100-081 D 86493

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 6 Elmhurst Road ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Thomas Glover

(a) RESIDENCE. No. 6 Elmhurst Road ST., 27 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 57 yrs. ? mos. ? ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Glover

6 DATE OF BIRTH (month, day, and year) Oct 3/1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Harbourn England

PARENTS

10 NAME OF FATHER Charles T. Glover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harbourn England

12 MAIDEN NAME OF MOTHER Caroline Osborne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harbourn England

14 Informant Wm. J. B. Fallon - Son-in-Law (Address) 6 Elmhurst Road.

15 Filed MAY 1 - 1924 . 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28th, 1924, to Apr. 30th, 1924, that I last saw him alive on April 29th, 1924, and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme M. D.

4/30, 1924 (Address) 2014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 2 1924

20 UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86494

CERTIFICATE OF DEATH.

100-001

D 86494

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 Royal Apts St., 11 Ward)

Registered No.....

2-FULL NAME Mary Elizabeth Lyson Parran

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 711 Royal Apts St., ... Ward Resident

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds How long in U. S., if of foreign birth? 58 yrs. 2 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. A. Parran

6-DATE OF BIRTH (month, day and year) Feby-1-1866

7-AGE, 58 yrs. 2 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Catonsville Maryland

PARENTS.

10-NAME OF FATHER, A. Robert Carter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Mary A. Boyd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Phila. Penna

14- (Informant) Dr. L. Parran (Son)

(Address) 711 Royal Apts.

15- MAY 1 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29-1924

17- I HEREBY CERTIFY, That I attended deceased from April 18 ....., 19 24, to April 29 ....., 19 24

that I last saw h.. alive on April 29 ....., 19 24

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ....yrs. ....mos. 11 ds.

CONTRIBUTORY (Secondary) Ac Pleurisy and Ac Nephritis

(Duration) ....yrs. ....mos. 10 ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard L. French, M. D.

(Address) 707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cemetery

DATE OF BURIAL, May 1, 19 24

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS, 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86495

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 86495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S Marine Hospital #1

CITY OF BALTIMORE: (No. Baltimore, Md ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wright.

(a) RESIDENCE NO. U.S Marine Hospital Baltimore Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Waiter 086

(c) Name of employer S/S Anne Arundel

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self (Deceased) (Address)

15 MAY 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1924, to April 29, 1924,

that I last saw h— alive on April 29, 1924,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) M. A. Foster, M. D.

19 (Address) U.S. Marine Hospital Baltimore Md

*To state the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 4/30 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86496

CERTIFICATE OF DEATH.

D 86496

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 McCulloh St. 11 WARD)

REGISTERED NO. 74-00 D 86496

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margrett Church

(a) RESIDENCE. No. 1202 McCulloh ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Grace Garrison

(Address) 1202 McCulloh St.

15 Filed MAY 1 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1924

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1924, to April 29, 1924, that I last saw h[illegible] alive on April 29, 1924, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Farnum M. D.

(Address) 712 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury Md	May 19[illegible]
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1726 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Williams

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86497

CERTIFICATE OF DEATH.

91-002 D 86497

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Lanvale ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Williams

(a) RESIDENCE NO. 706 Lanvale ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 015

(b) General nature of industry, business, or establishment in which employed (or employer) Confectionery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. R. G. Elbert

(Address) 1223 Eastern Ave

15 Filed MAY 1 - 1924, 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1924, to April 28, 1924.

that I last saw him alive on April 27, 1924,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) — 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home address

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Stevens M. D.

, 19 (Address) 1704 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL May 1 1924

20 UNDERTAKER Mrs. R. G. Elbert

ADDRESS 1223 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86498

CERTIFICATE OF DEATH.

74-001

74 D 86498

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Harford Ave ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Bell

(a) RESIDENCE NO. 718 Harford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer unknown

9 BIRTHPLACE (city or town) .....
(State or country) unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Elizabeth Robinson
(Address) 718 Harford Ave

MAY 1 - 1924

ROBERT R. KRAUER
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 28/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteiosclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Hollman (Coroner.), M. D.

Apr 30/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	5/4 192 4
20 UNDERTAKER	ADDRESS
Joseph D. Rochester	1453 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

170 D 82 86499

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 86499

CERTIFICATE OF DEATH.

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gross.

(a) RESIDENCE NO. 1135 Strickersett WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
19	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mathilda Bryden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Record. (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 1 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1924, to April 28, 1924.

that I last saw him alive on April, 1924,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic endocarditis, Mitral stenosis and insufficiency, myocardial failure.

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Hammon, M. D.

4-27-24 19 (Address) Johns Hopkins Hospkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn century — DATE OF BURIAL 19

20 UNDERTAKER Mrs James H. Dennis — ADDRESS 1305 Fremont St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86500

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 N Carrollton St. Ward 16)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Hall

(a) RESIDENCE No. 1148 N. Carrollton Ave. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-24-1924

7 AGE — Years — Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Md~~ Md

PARENTS

10 NAME OF FATHER Earl Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Earl Hall

(Address) 1148 Carrollton Ave

15 Filed MAY 1 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29-1924

17 I HEREBY CERTIFY, That I attended deceased from 4-24-1924 to 4-29-1924, that I last saw h alive on 4-28-1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Seven month child. (Premature)

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D. Hanyin, M. D.

4-30, 1924 (Address) 611 - N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery — DATE OF BURIAL: May 1924

20 UNDERTAKER: Jesse Redden — ADDRESS: 436 Bradford St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Rw gobke 900 N. Bel-Park Av.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8650I

CERTIFICATE OF DEATH.

11-001

D 8650I

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1941 Patterson Park Ave. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hilda Mae Wells-

(a) Residence No. 1941 Patterson Park Ave. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 10 1910

7-AGE, 14 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Mfg.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Pa.

PARENTS.

10-NAME OF FATHER Leonard Wells.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Blanche Gordon

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Pa

14- (Informant) Mrs. Leonard Wells

(Address) 1941 Patterson Park Ave

15- Filed MAY 1 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 18, 1924 to April 29, 1924

that I last saw h... alive on April 29, 1924

and that death occurred, on the date stated above, at 1936 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Brownell M. D.

(Address) 430 19 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Pearlstone Park Cem. DATE OF BURIAL, May 2, 1924

20-UNDERTAKER Wm Cook ADDRESS 502 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Lib 2575

Poulton 3902 Garrison Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86502

CERTIFICATE OF DEATH.

91-09 D 86502

1-PLACE OF DEATH

City of BALTIMORE: (No. 518 E. 21st St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Hall

(a) Residence No. 518 E. 21st St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor

6-DATE OF BIRTH (month, day and year) May 6-1836

7-AGE, 87 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Coach

(b) General nature of industry, business, or establishment in which employed (or employer): P.R.R. Co 004

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Robert Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs W. Coale

(Address) 2947 N. Calvert

15- Filed MAY 1 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr 29 1924

I HEREBY CERTIFY, That I attended deceased from Jan 4th 1923 to April 29th 23, that I last saw him alive on April 28th 23, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Edema of Lower Lungs

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Poulton M. D.

4/30/24 (Address) 3909 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Coach — DATE OF BURIAL: 5/2 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 501 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86503 HEALTH DEPARTMENT—CITY OF BALTIMORE

118-09 D 86503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St Agnes Hosp St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Schultz

(a) Residence No. 2100 N. Pratt St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 7-1896

7-AGE. 27 yrs. 8 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... At home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Schultz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Henrietta Hesse

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Albert Schultz

(Address) 2100 N. Pratt St

Filed MAY 1 - 1924 192.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 4-30-1924

17- I HEREBY CERTIFY, That I attended deceased from 4-22 19 24 to 4-30 19 24

that I last saw her alive on 4-30 19 24

and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

General Peritonitis (Acute)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) S. Goldsmith, M. D.

, 19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 2, 1924

20-UNDERTAKER: George L. Schwab — ADDRESS: 1301 Druid Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 86504

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Hoffman ST., 17 WARD)

2-FULL NAME Delia Coleman

(a) RESIDENCE NO. 523 N. Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Silas Coleman

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 90

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairmount Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Florence Chase (Address) 523 N. Hoffman St

15 MAY 1 -1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29. 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19th 1924 to April 29th 1924.

that I last saw her alive on April 28th 1924.

and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. de Ellis, M. D.

4/29. 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cemetery	May 2 1924
20 UNDERTAKER John H. Owens	ADDRESS 538 Dolphin Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 ✓ D 86505

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1320 W Lexington St., 19 WARD)

2-FULL NAME Fannie Leibschultz

(a) RESIDENCE NO. 320 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of ~~HUSBAND of~~ Fritz Leibschultz

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER J Levi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rebecca Philips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mr. Marlin Leibschultz (Address) Bridgeville N. J.

15 Filed MAY 1 - 1924 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to April 30, 1924, that I last saw h[illegible] alive on April 29, 1924, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

Senility (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Bernard S. Levi M. D.

4/30, 1924 (Address) 170 7 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Damascus Pennsylvania	May 2 1924
20 UNDERTAKER	ADDRESS
Wilbur W. Shivler	1018 Edmondson Ave.

Spec.—1-10-21—M&T—1500 Bks.

D 86506

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86506

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Sheppard

(a) RESIDENCE NO. 2180 Decker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Charles D.

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Collin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER K. Beard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS H.... (Address)

15 MAY 1 - 1924 Robert N. KRAUER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1924, to April 29, 1924, that I last saw h[illegible] alive on April 29, 1924, and that death occurred, on the date stated above, at 1 05 p m.

The CAUSE OF DEATH* was as follows:

Uremia, nephritis

about 4-5 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of Nephritis, (duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood studies

(Signed) [illegible] M. D.

4/30, 1924 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL May 2 1924

20 UNDERTAKER Robt F Turner

ADDRESS 1442 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 D 1426 86507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 86507

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 7 WARD)

2-FULL NAME Addie Hoffman

(a) RESIDENCE NO. Morgantown, W. Va. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Harley Hoffman

6 DATE OF BIRTH (month, day, and year) ——— 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Luther Luther

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Steele ———

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 MAY 1 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1924 to April 30, 1924.

that I last saw her alive on April, 1924,

and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - non-malignant

(duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of Ap 30-1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Winfield M Fisher, M. D.

5/1, 1924 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morgantown W Va	5/1/24
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1743 19 86508

CERTIFICATE OF DEATH.

X73 D 86508

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace R. Martin

(a) RESIDENCE No. 1020 Buckhill Ave (Usual place of abode) Miami Fla WARD Miami Fla. (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 19, 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John H. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Helen E Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 1 - 1924 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1924, to May 1, 1924, that I last saw h[illegible] alive on May 1, 1924, and that death occurred, on the date stated above, at 7.50 a.m.

The CAUSE OF DEATH* was as follows:

Progressive Muscular Atrophy

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory paralysis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) Treva Omeis, M. D.

May 2 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Miami Fla	May 1 1924

20 UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 86509

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86509

CERTIFICATE OF DEATH.

57

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2737 N. Calvert St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Biemiller

(a) Residence No. 2737 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 0 mos. — ds. How long in U. S., if of foreign birth? 63 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, ~~Married,~~ Widowed, or ~~Divorced,~~ (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John B. Biemiller

6-DATE OF BIRTH (month, day and year) July 28 1845

7-AGE. 78 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ~~None~~

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Leonard Riedel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Eunstine St Remy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Mamie Brill

(Address) 2737 N. Calvert St

15- Filed ..... Robert P. Garrison Registrar.

MAY 1 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1. 1924 to apl. 30 1924

that I last saw her alive on Apl. 30 1924

and that death occurred, on the date stated above, at 5-30 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Robert C. Blade M. D.

, 19 (Address) 1014 W Fa Joyce

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, May 2 19 24
20-UNDERTAKER, Jos Socrsdens Son	ADDRESS 2178 E. Pres

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86510

CERTIFICATE OF DEATH.

19 57

D 86510

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1503 Henry St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary A. Elliott

(a) Residence No.. 1503 Henry St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 7 mos. 12 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: George Elliott

6-DATE OF BIRTH (month, day and year): Sept. 19, 1854

7-AGE: 69 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Wm. Kane

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary A. Gleason

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Geo. Elliott (Son)

(Address): 1503 Henry St.

15- Dated 1924 Robert P. Garrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4. 29. 24.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1924, to April 29, 1924, that I last saw h.. alive on April 28, 1924, and that death occurred, on the date stated above, at 11 a. m.

THE CAUSE OF DEATH* was as follows: Diabetes Mellitus, Generalized Arteriosclerosis, Chronic Nephritis; Myocarditis with Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Durntion) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory findings

(Signed) Edward Davis, M. D.

5-1-24. 19 (Address) 107 E West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral | DATE OF BURIAL: May 3, 1924

20-UNDERTAKER: Edward J. Flynn | ADDRESS: 422 Light St

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 1

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 8651E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 8651E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Mura ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sura T. Flichman

(a) RESIDENCE. No. 2222 Mura ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Flichman

6 DATE OF BIRTH (month, day, and year) May. 5/1860.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63.	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester Carroll Co. Maryland

PARENTS

10 NAME OF FATHER Michael Dirtz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Yost.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Jacob Flichman (Address) 2222 Mura St

15 Filed MAY 2 - 1924 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1924. to April 30. 1924.

that I last saw h.. alive on April 30 1924

and that death occurred, on the date stated above, at 3 25 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

1, 1924 (Address) 120 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden.	5/3rd 1924
20 UNDERTAKER Stella Davis	ADDRESS 3307 Paine St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86512 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86512

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 202 N. Ellwood Ave. 6

CITY OF BALTIMORE: (No. ..... ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Curtis Brady

(a) RESIDENCE NO. 202 N. Ellwood Ave. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 9 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katharine Sheehan

6 DATE OF BIRTH (month, day, and year) July 26, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	41	9	N	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 069

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer American Hotel Supply Co.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John C. Brady

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary M. Keady

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lowestoft Eng.

14 Informant Mrs. Katharine J. Brady
(Address) 202 N. Ellwood Ave

15 Filed MAY 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1924, to April 30-May 1 1924

that I last saw him alive on April 30 1924,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Uremia, myocardial insufficiency

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hypertension, chronic nephritis (duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) L. C. Dobihal, M. D.

. 19 (Address) 447 N. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 3 1924
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	1025 N. Calvert St.

Spec—12-23-21—E.B.R.S.—400 Blks.

Blachowicz

D 86513 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2233 Eastern Avenue St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph Blachowicz .....

(a) Residence No. 2233 Eastern Avenue St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Marri[illegible]

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) Zofia Blachowicz

6-DATE OF BIRTH (month, day and year) Dec 8 1882

7-AGE.	If LESS than 1 day,
41 yrs. 4 mos. 22 ds.	....hrs. or.... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Mixing Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer)..... Tele Inner Rubber Co.

(c) Name of employer..... Rubber Tire Co. Orange

9-BIRTHPLACE (city or town)..... Poland
(State or Country).

PARENTS.

10-NAME OF FATHER, Michael Blachowicz

11-BIRTHPLACE OF FATHER (city or town)..... Poland
(State or Country).

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Poland
(State or Country).

11- (Informant) Mrs. Zofia Blachowicz

(Address) 2233 Eastern Avenue

15- Filed MAY 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 30 192[illegible]

17- I HEREBY CERTIFY, That I attended deceased from Apr. 28 24 to Apr. 30 24

that I last saw [illegible] alive on Apr 30 19 24

and that death occurred, on the date stated above, at 1245 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D

19 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	May 3 1924

20-UNDERTAKER,	ADDRESS
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86514

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 B 01 D 86514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 114 S. Collington ave Ward 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Philip J. Meagher

(a) Residence No. 114 S. Collington ave St., ... Ward 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND (~~of (or) WIFE of~~) Sarah E. Meagher

6-DATE OF BIRTH (month, day and year) Feb. 19th 1848

7-AGE, 76 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Butcher

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Meagher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Donnelon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Sarah E. Meagher

(Address) 114 S. Collington ave

15- Ward ..... 19..... ROBERT R. KRAUTER, Registrar.

MAY 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 29 24

17- I HEREBY CERTIFY, That I attended deceased from ~~from Jan 22 - to the 29th inst.~~

Jan 1, 1924, to April 29, 1924,

that I last saw h.m alive on April 29, 1924,

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Cerebral Hg

Paralysis Duration 1 yr

from Carcinoma of Jaw

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Manuel A. Cruz M. D.

, 19 (Address) 3325 Patapsco

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, May 2 1924

20-UNDERTAKER, John A. Moran — ADDRESS 3000 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 86515

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Freindly Inn Aged Home 5 St., ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mayer Goldberg

(a) Residence No. 115 Aisquith Street St., ...Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (~~Write the word.~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ray Goldberg

6-DATE OF BIRTH (month, day and year) Unkown

7-AGE 104 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Old Age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER. Unkown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unkown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- Jack Lewis (Informant) 1439 E Baltimore St (Address)

15- MAY 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1 24

17- I HEREBY CERTIFY, That I attended deceased from April 21 1924 to May 1 1924

that I last saw ~~him~~ alive on May 1 1924

and that death occurred, on the date stated above, at 2 15 p m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Nat Bayline M. D

5/1, 1924 (Address) 820 Aisquith

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Mt Carmel Cem

DATE OF BURIAL. 5 2 24 19....

20-UNDERTAKER. Jack Lewis

ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86516

D 86516

CERTIFICATE OF DEATH.

5-7

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 3 WARD)

2-FULL NAME Yetta Tilles

(a) RESIDENCE NO. 1103 E Lombard St ST., ... WARD .....

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Tilles

6 DATE OF BIRTH (month, day, and year) Unkown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country) Unkown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Max Tilles
(Address) 842 W Saratoga St

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplezy-hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellites

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos H Collen, M. D.
(Coroner)

May 1st, 24 , 192 (Address) 300 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Carmel

DATE OF BURIAL 5/2 1924

20 UNDERTAKER Jack Levis

ADDRESS 1429 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17-46 D 86517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 46 D 86517

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 15 ST., WARD)

2-FULL NAME Mollie Sneed

(a) RESIDENCE NO. 1414 N. Mount ST., WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 1/2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
~~Female~~ ~~Male~~	Black	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William Sneed

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Robert Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lucy Burial

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address) JOHNS HOPKINS HOSPITAL ROBERT R. KRAUTER

15 MAY 2 - 1924 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to April 30, 1924.

that I last saw her alive on April 30, 1924.

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of cervix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 4/2/24.

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Reed B. Windle, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Henry N. C.	May 3, 24
20 UNDERTAKER	ADDRESS
Samuel L. Stanley	N. Bdle

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17139 97

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 86518

D 86518

CERTIFICATE OF DEATH. X 118-00

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Alice Fleming

(a) RESIDENCE NO. 1522 McCulloh St WARD Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced (or) WIFE of Leonard Fleming

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Henretta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL.

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to April 29, 1924, that I last saw her alive on April 29, 1924, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction;

(duration) 2 weeks yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) myocardial disease

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 22

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) J. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mallenbert Mt Co Va	May 2, 1924
UNDERTAKER Samuel B Wheeler	ADDRESS 5 E Eddie

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86519

CERTIFICATE OF DEATH.

1924 D 86519

REGISTERED No. C.....

1-PLACE OF DEATH First Ave & 16th St

CITY OF BALTIMORE (No. 4820 - 1st ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Caush

(Residence in Baltimore: No. 4820 - 1st ave St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Child

6-DATE OF BIRTH, Sept 5, 1918
(Month) (Day) (Year)

7-AGE, 4 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Chas Caush

11-BIRTHPLACE OF FATHER (State or Country) Austro Hung

12-MAIDEN NAME OF MOTHER Anna Citkowska

13-BIRTHPLACE OF MOTHER (State or Country) Austro Hung

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Caush

(Address) 4820 1st St.

15-
MAY 2 - 1924
(Date) ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental.
Drowning

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

....., 191... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
St Stanislaus Cem	May 5, 1924
20-UNDERTAKER	ADDRESS
Stephen L Trakowski	1005 Fairmount Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 86520

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86520

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Fleet ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jankowiak,

(a) RESIDENCE NO. 1917 Fleet ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Jankowiak,

6 DATE OF BIRTH (month, day, and year) July --- 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) Day laborer,

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Thomas Jankowiak,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary Wawrzyniak,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Frances Jankowiak, (Wife)

(Address) 1917 Fleet Street

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, (Registrar)

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/30 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1924, to 4/30, 1924, that I last saw h[im] alive on 4/28, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Emphysema following Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Maurice B. Fiske, M. D.

, 19 (Address) 3326 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. STANISLAUS CEMETERY

DATE OF BURIAL: May 3rd 1924

20 UNDERTAKER: M. F. Sadowski,

ADDRESS: 705 S. Ann St

Spec— 12-23-21—E.B.R.S.—400 Bks.

Jacot Levinson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86521

D 86521

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 718 Newington Ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jaboc Levinson

(a) Residence No. 718 Newington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Adela Levinson

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0 80

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS:

10-NAME OF FATHER. Louis Levinson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER. Unkown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- Jack Lewis (Informant) 1439 E Baltimore St (Address)

15- MAY 2 - 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-1-24

17- I HEREBY CERTIFY, That I attended deceased from Apr 23 1924 to May 1 1924

that I last saw h. alive on May 1 1924

and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D

5/1, 1924 (Address) 733 Aisquith St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Washington D.C. DATE OF BURIAL. 5/2 1924

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86522

CERTIFICATE OF DEATH.

129 D 86522

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Eugene O'Hara

(a) RESIDENCE NO. 1642 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Margaret S. O'Hara

6 DATE OF BIRTH (month, day, and year) Apr 19 76

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman at Hat

(b) General nature of industry, business, or establishment in which employed (or employer) Straw Hat

(c) Name of employer Factory

9 BIRTHPLACE (city or town) (State or country) City Cuba

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret S. O'Hara

(Address) 1642 E. Federal St

MAY 2 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to April 30, 1924, that I last saw him alive on April 30, 1924, and that death occurred, on the date stated above, at 4 35 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Uraemia

Cardiac dilatation Chr. Endocarditis Arteriosclerosis & hypertension (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - Cholecystitis & cholelithiasis (duration) yrs. mos. ds.

If Where was disease contracted if not at place of death? 1642 N. Bond St.

Did an operation precede death? yes Date of April 23/24

Was there an autopsy? no.

What test confirmed diagnosis? Usual evidence

(Signed) Geo. B. Tyler, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL 5/3 1924

20 UNDERTAKER Philip Henry

ADDRESS 2016 Orleans

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86523

CERTIFICATE OF DEATH.

99-00

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Louis Cartonie

(a) Residence No..... Preston & Valley Sts. St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Henriette Giudice

6-DATE OF BIRTH (month, day and year) 15 May 1860

7-AGE, 63 yrs. 11 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... Gd

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Dominic Cartonie

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country),

12-MAIDEN NAME OF MOTHER, Raphaelle Compagno

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country),

14-

(Informant)... Sister Florence.....

(Address)... Preston & Valley.....

15-

Filed..... 192.. ROBERT R. KRAUTER, Registrar.

MAY 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 30 '24

17- I HEREBY CERTIFY, That I attended deceased from No record 19..... to ..... 19.....

that I last saw h. ~~corpse~~ alive on ..... June 7 '24

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute bronchitis

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

May (Signed) F. L. Warner, M. D.

1 . 19 24 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, May 2, 1924

20-UNDERTAKER, J. C. Winfield — ADDRESS 914 Gruman Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86524

CERTIFICATE OF DEATH.

1924 D 86524

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Joseph Ferrell

(a) RESIDENCE NO 648 Josephine St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer do
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Don't Know

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs. [illegible] Ferrell
(Address) 648 N. Josephine St.

15 MAY 2 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or [illegible]) thereon and from the evidence obtained by said ..... (Inquest, autopsy or [illegible]) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound in abdomen

(Duration) ..... yrs. a few mos ..... ds.

Shot by Grant Burns

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Tench (Coroner.), M. D.

5/2-, 1924 (Address) 1117 Dawson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 7 1924
20 UNDERTAKER	ADDRESS
R. C. Goss	1405 N. Eldenwood

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86525

CERTIFICATE OF DEATH.

90 D 86525

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Mens Home St., 19 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Wm. L. Turner

(a) Residence No. 1400 N. Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widow

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 11 1846

7-AGE. 77 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). City Jail
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Wm L Turner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Estelle A Cusk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

(Informant)..... Matron Aged Mens Home

Address..... Aged Mens Home

ROBERT R. KRAUTER, Burial Permit Clerk.

MAY 2 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 1 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to May 1, 1924, that I last saw h...alive on May 1, 1924, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) J Norwood, M. D.

May 4 1924 (Address) 909 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	5/5/24 19....

20-UNDERTAKER.	ADDRESS
Ed J Smith	532 Hollins

MARGIN RESERVED FOR BINDING.

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH that it may be properly classified. Exact statement of OCCUPATION is very important. See back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

BARNES

D 86526

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86526

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3154 Cedar Ave. ST., 13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Kate B Barnes

(a) RESIDENCE No. 3154 Cedar Ave ST., 13 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam J. Barnes

6 DATE OF BIRTH (month, day, and year): May 5-1862

7 AGE: Years 61 | Months 11 | Days 24 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Ella M. Reid

(Address): 3154 Cedar Ave

15 MAY 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to April 29, 1924, that I last saw h[illegible] alive on April 29, 1924, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary): Pneumonia acute

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) H. Arthur Dorsey, M. D.

, 19 (Address) 4007 Bonaparte Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden)

DATE OF BURIAL: May 2 1924

20 UNDERTAKER: Horace A. Burgee

ADDRESS: 1[illegible] Gallstown

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

SWEENY

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86527

58-001 D 86527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hosp · ST. 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary J. Sweeny

(a) RESIDENCE No. 436 Roland Ave ST., 13 WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel A. Sweeny

6 DATE OF BIRTH (month, day, and year) March 2-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER William McAbee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie McCubbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant .....
(Address)

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Record

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1924.

17 I HEREBY CERTIFY, That I attended deceased from April 19th, 1924, to May 1st, 1924.

that I last saw her alive on May 1st, 1924.

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Exam.

(Signed) A. Curtis Evans, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 3 1924.
UNDERTAKER	ADDRESS
Horace K. Burgee	303 Fallsway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21 D 86528

D 86528

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 W. Fayette ST., 19 WARD)

2-FULL NAME Mrs. Annie Clark Kaldenbach

(a) RESIDENCE NO. 1422 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mathias John Kaldenbach

6 DATE OF BIRTH (month, day, and year) Nov 2 55

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	68	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Adam G Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Clark.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Miss Bessie Kaldenbach
(Address) 1422 W Fayette st

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar

MAY 2 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1924.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23rd, 1924, to May 1st, 1924,

that I last saw h er alive on Apr. 30th, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Erysipelas Migrans,

..... (duration) ..... yrs. ..... mos 8 da 9 ds.

CONTRIBUTORY X
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Only symptoms & Signs

(Signed) O. H. Hoffman M. D.

. 19 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 3 1924
20 UNDERTAKER W M Rowton	ADDRESS 225 N Howard

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 86529

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1351 Ramsey St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sebury Tobin

(a) Residence No. 1351 Ramsey St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Ann Tobin

6-DATE OF BIRTH (month, day and year) Sept 3, 1844

7-AGE, 79 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, John Tobin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary J. Hanly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Ann Tobin

(Address) 1351 Ramsey St

15- MAY 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 20, 1924, to May 1, 1924, that I last saw h.... alive on April 30, 1924, and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. O'Neill M. D.

5/1, 1924 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	May 3, 1924

20-UNDERTAKER.	ADDRESS
John Field & Son	Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86530

CERTIFICATE OF DEATH.

90 D 86530

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S. Stricker St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Brennan

(a) RESIDENCE No. 235 S. Stricker St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Brennan

6 DATE OF BIRTH (month, day, and year) Sept. 26, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Sharkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Lennon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Frank McGuire

(Address) 235 S Stricker St

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1921, to Apr. 27, 1924, that I last saw her alive on " " , 1924, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 5 Yrs.

Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N. D. Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Cashman, M. D.

5/1/24 (Address) 24 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 5 19 24

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

86531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 | D 8653E

1-PLACE OF DEATH

City of BALTIMORE: (No. 1721 Harlem Avenue St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Bernard Sherry

(a) Residence No. 1721 Harlem Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth A.Sherry

6-DATE OF BIRTH (month, day and year) Aug.27,1895

7-AGE, 28 yrs. 8 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work travelling Car

(b) General nature of Industry, business, or establishment in which employed (or employer) Agent B and O. Railroad

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Wm. B. Sherry

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Minnie E.Wendel

13-BIRTHPLACE OF MOTHER (city or town) Virginia (State or Country)

14- (Informant) Mrs.Elizabeth A.Sherry

(Address) 1721 Harlem Ave.

15- Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 30, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1923 to April 30, 1924

that I last saw him alive on April 29, 1924

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Streptococcus Viridans

Septicemia

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) Howard W. Jones, M. D.

4-30-1924 (Address) Augusta & Frederick Aves

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loyola Park Cem DATE OF BURIAL. May 3 1924

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86532

CERTIFICATE OF DEATH.

46 D 86532

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Mrs. Gertrude Morton~~ Women's Hospital ST., 9 WARD)

2-FULL NAME Mrs. Gertrude Morton

(a) RESIDENCE NO. 2011 E. 3rd ST. Balto. Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Calvin H. Morton

6 DATE OF BIRTH (month, day, and year): July 16 1875

7 AGE — Years: 48 — Months: 9 — Days: 17 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House duties

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: Enos P. Pulle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Harriet M. Bean

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Calvin H. Morton (Address) 2011 E. 3rd St.

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25, 19 24, to May 2 19 24, that I last saw h.. L alive on May 2 19 24, and that death occurred, on the date stated above, at 5 15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolis

(Immediate death)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Multilocular ovarian cyst (left) malignant

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 26, 1924

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. W. Sickel, M. D.

19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sabina Ohio — DATE OF BURIAL: May 3 1924

20 UNDERTAKER: Otterbach — ADDRESS: 1201 E. Fayette

Burial Permit Stock.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86533

111-0 D 86533

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

2-FULL NAME Ernest B. Lotham

(a) RESIDENCE NO. 535 W. Preston ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Geo. Bloxom.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Record

(Address)

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1/1924

17 I HEREBY CERTIFY, That I attended deceased from 4/2/24, to 5/1/24, 19 ,

that I last saw h alive on 5/1/24, 19 ,

and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Tertian Malaria

Ruptured.

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Peritonitis Acute.

(duration) ..... yrs. ..... mos. 6. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 4/27/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) R. W. Hall, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Nancock Va — DATE OF BURIAL 5-2-1924

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pine

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86534

CERTIFICATE OF DEATH.

100-001

D 86534

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3427 Fostertown St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Joseph Tegtan

(a) Residence No. 3427 Fostertown St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Mar 2-1923

7-AGE. 1 yrs. 2 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Nurse Tend

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto

(State or Country),

PARENTS.

10-NAME OF FATHER, Stanley Tegtan

11-BIRTHPLACE OF FATHER (city or town) Balto

(State or Country),

12-MAIDEN NAME OF MOTHER, Frances T Schultz

13-BIRTHPLACE OF MOTHER (city or town) Balto

(State or Country),

14- (Informant) Stanley Tegtan

(Address) 3427 Fostertown

15- Filed MAY 2 - 1924 ROBERT B. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 30 1924

17- I HEREBY CERTIFY, That I attended deceased from April 28 1924 to April 30 1924

that I last saw h... alive on April 30 1924

and that death occurred, on the date stated above, at 1:20 A M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward L Kurtz M. D

4/30 1924 (Address) 4127 Washington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL. May 3 1924

20-UNDERTAKER, Lilly & Zeiler ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86535

D 86535 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Owens

(a) Residence No. 24 W. Church st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1885

7-AGE.	If LESS than 1 day.
38 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Edward Owens

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Mary Fowler

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- MAY 2 - 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Apr. 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from August 13, 1924 to April 29, 1924

that I last saw him alive on April 29, 1924

and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? N

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lathy M. D

4-29-24 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND DATE OF BURIAL. MAY 2 - 1924

20-UNDERTAKER, ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

38

Cor. 4-12-23—M&T—100 Bks.

D 86536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Etting Se ST., 14 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manuel Henry

(a) RESIDENCE No. 1709 Etting Se ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Henry

6 DATE OF BIRTH (month, day, and year) June 7 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34 yrs.	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O to
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Alfred Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Pinkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emma Pinkett

(Address) 140 S Wolfe

MAY 2 - 1924

Registrar ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(Duration of Illness)

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) acute dilatation of heart

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Kennedy, M. D.

(Coroner.)

May 1, 192 4 (Address) 2 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M & Suburban	May 2 1924
20 UNDERTAKER Sam W. Fuse Sons	ADDRESS 1400 Mad Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAKING OR RECEIVING BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86537 ✓ 16-002 D 86537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Briza

(a) RESIDENCE No. 930 N. Duncan St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	~~Col~~ White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) July 28/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Stanislau Briza

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Catherine Wachowick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Catherine Braza
(Address) 930 N. Duncan St

Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Broncopneumonia

(Autopsy at Hopkins Hospital)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dysentery (duration) yrs. mos ds.

(Signed) J. S. Wallen, M. D. (Coroner.)

May 2 1924 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	5/5/24
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	121 E Lights

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86538

CERTIFICATE OF DEATH.

101 D 86538

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1214 Parrish ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lizzie Samuels

(a) RESIDENCE. No. 1214 Parrish ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Richard Samuels Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 48 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of Industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Montgomery Co Md

PARENTS

10 NAME OF FATHER: William King

11 BIRTHPLACE OF FATHER (city or town) (State or country): Montgomery Co Md

12 MAIDEN NAME OF MOTHER: Lizzie King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): — Md

14 Informant (Address): Lizzie Samuels 1214 Parrish

MAY 2 - 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 29th 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26th 1924 to Apr. 29th 1924, that I last saw h-e alive on Apr. 29th 1924, and that death occurred, on the date stated above, at 11:35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Clarence Hall, M. D.

, 19 (Address) 1724 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn cemetery	May 2 1924
20 UNDERTAKER	ADDRESS
Edward Ryan	1631 Division

Spec-12-23-21-E.B.R.S.-400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86539

CERTIFICATE OF DEATH.

90 D 86539

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1502 Riverside Ave. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Deck

(a) Residence No. 1502 Riverside Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write this Word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick N. Deck

6-DATE OF BIRTH (month, day and year) May 10 1869

7-AGE. 54 yrs. 11 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Hagerstown Md.

PARENTS.

10-NAME OF FATHER: Jacob Renner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Hagerstown Md

12-MAIDEN NAME OF MOTHER: Sarah Middlekaupf

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Hagerstown Md.

14-(Informant): Mr. F. N. Deck (Husband)

(Address): 1502 Riverside Ave.

15-Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 1st 1924

17-I HEREBY CERTIFY, That I attended deceased from June 29 1923 to May 1st 1924

that I last saw h. alive on May 1st 1924

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) 1 yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John [illegible] M. D

[illegible] 2 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hagerstown Md.	May 4 1924
20-UNDERTAKER. J. Fenw McCully	ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86540

CERTIFICATE OF DEATH.

129 D 86540

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Argyle ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Simms

(a) RESIDENCE NO. 1324 Argyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Hamon Whitcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Simms, Son

(Address) 1324 Argyle St.

15 Filed ... 1924 ROBERT R. KRAUTER, Registrar

MAY 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to Apl 30, 1924,

that I last saw h[illegible] alive on April 30, 1924,

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Ends Carcinoma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. Pearce M. D.

5-2, 1924 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	May 3 1924
20 UNDERTAKER	ADDRESS
Wm McCausland	2107 Reisterstown Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8654I

CERTIFICATE OF DEATH.

90 D 8654I

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 E. Church St. 27 WARD)

2-FULL NAME Robert Creighton Jr.

(a) RESIDENCE. No. 725 E Church ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer) glass house.

(c) Name of employer Swindell.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Creighton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Jane Gable.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm Creighton.

(Address) 727 E. Church St

15 Filed MAY 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15 1924, to 5/1 1924, that I last saw h.. alive on 4/30 1924, and that death occurred, on the date stated above, at 1130a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F. Edw Emrich, M. D.

5/1, 1924 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	May 3rd 1924
20 UNDERTAKER	ADDRESS
C. Schlosman & Son	1089 Hanover St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

GENERAL DIRECTIONS.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 86542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 86542

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S Montford ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Serbin

(Residence in Baltimore: No. 626 S Montford ave St.; 16 yrs., mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (write which) Married

6-DATE OF BIRTH, April 30, 1888 (Month) (Day) (Year)

7-AGE, 36 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Poland

PARENTS.

10-NAME OF FATHER Martin Serbin

11-BIRTHPLACE OF FATHER (State or Country) Poland

12-MAIDEN NAME OF MOTHER K. Zamoyska.

13-BIRTHPLACE OF MOTHER (State or Country) Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexandra Serbin

(Address) 626 S. Montford ave.

15- Robert P. Harrison,

Filed MAY 2 - 1914, 191.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 29, 1914 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 22 1914, to 4/29 1914, that I saw him alive on 4/29 1914, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. J. Harding M. D.

5/2, 1914 (Address) 716 E. Fayette st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary Cem DATE OF BURIAL, May 3, 1914

20-UNDERTAKER F H Ozazewski ADDRESS ~~1780~~ 1930 Eastern Ave

D 86543

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital Ward) 185

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charlotte Sanders

(Residence in Baltimore: No. 322 E. 21th St. Ward, yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. (a) March (Month) 10 (Day) 1848 (Year)

7-AGE. 76 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 837

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Edward Crew

11-BIRTHPLACE OF FATHER, (State or Country). Kent Co.

12-MAIDEN NAME OF MOTHER. Ama Kelly

13-BIRTHPLACE OF MOTHER, (State or Country). Kent Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. D. Hickey

(Address) 322 E. 21th St.

15- Dec 1924 Robert P. Harrison, 192..... Registrar.

Burial Permit Clerk

MAY 2 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. April (Month) 30 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture L. Femur
of hip. by fall in her
home Accident

(Duration) ....yrs. ....mos. 1½ ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) 4 yrs. ....mos. 4 ds.

(Signed) James M. Fenton M. D.
(Coroner.)

May 1 1924 (Address) 708 E. Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. 1½ ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 322 E. 21st St.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cemetery	May 3. 1924

20-UNDERTAKER,	ADDRESS
N. E. Stiles	320 Md. Ave Westport

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86544

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86544

188-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Pronounced dead at

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine M. Buchta

(a) RESIDENCE NO. 816 N.Lakewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
XXXXX

6 DATE OF BIRTH (month, day, and year) July 4/1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	9	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frank J. Buchta

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Vogel

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Minnie V. Buchta
(Address) 816 N. Lakewood Ave

15 Filed MAY 2 - 1924, 192 Robert F. Carrison
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Skull-Autotruck accident

(INquest to be held)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

(Signed) J. S. H. Culler, M. D.
(Coroner.)

May 12/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 3 1924
20 UNDERTAKER	ADDRESS
Wm. J. Schaefer	846 Fremont

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1401 Kuper Place St., 19 Ward) 49

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard D. Wolfe

(a) Residence No. 1401 Kuper Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Wolfe

6-DATE OF BIRTH (month, day and year) Unk — 1862

7-AGE. 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer) helper 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Mrs Ellen Wolfe

(Address) 1401 Kuper Place

15- Filed MAY 2 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 30 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1924 to April 30 1924

that I last saw h— alive on April 29 1924

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 3/1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eden [illegible] M. D.

5/1, 1924 (Address) 517 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 2nd 1924
20-UNDERTAKER	ADDRESS
Harry H. Amacost	4204 Ridgewood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D 86546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86546

CERTIFICATE OF DEATH.

65-007

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 E Fairmount Av ST.: 6 WARD)

2-FULL NAME Rose Mary Smith

(a) RESIDENCE. No. 1901 E Fairmount Av ST., ... WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓ ✓ ✓

6 DATE OF BIRTH (month, day, and year) Nov 28-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore.
10 NAME OF FATHER John R Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Elizabeth Smith
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Paul Smith
(Address) 3122 Fait Ave

15 Filed MAY 2 - 1924 . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1- 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9th. 1924. to May 1st. 1924.
that I last saw her alive on May 1st. 1924.
and that death occurred, on the date stated above, at 6-45 P m.
The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Ac Bronchitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? Blood Etc.

(Signed) Benjamin Cleary, M. D.
(Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	5/3 1924
20 UNDERTAKER	ADDRESS
Chas H Grandt Son	118 W Mt Royal Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86547

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 Forest St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... William J. McGraw

(a) Residence No. 710 Forest St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): Oct 12. 1875

7-AGE, 48 yrs. 6 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fireman Saloon

(b) General nature of Industry, business, or establishment in which employed (or employer): 040

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Wm. McGraw

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Margaret McGuinn

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Mrs. Julia Bouchet

(Address): 710 Forest St.

15- Filed MAY 2 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 1 1924

17- I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to May 1, 1924

that I last saw him alive on May 1, 1924

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Pulmonary Th

(Duration) yrs. ? mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) D. E. Bornstein, M. D.

19 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral	May 5 1924
20-UNDERTAKER	**ADDRESS**
Elmer W. Conklin	924 E Eager

INSTRUCTIONS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86548

D 86548

CERTIFICATE OF DEATH.

71-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 S. Pulaski ST. 20 WARD)

2-FULL NAME William F. Smith Jr

(a) RESIDENCE NO. 318 S. Pulaski ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs, mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 - 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm A. Smith

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Louise Long

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant William F. Smyth
(Address) 318 S. Pulaski St

15 Filed MAY 2 1924, Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1924, to April 30, 1924, that I last saw h alive on April 30, 1924, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(duration) yrs. mos 2½ ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 1735 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Weston Cemetery	May 3 1924
20 UNDERTAKER George L. Schmidt	ADDRESS 1701 Pulaski St

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86549

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86549

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2145 Hollins ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Annie~~ Annie J. Albiker

(a) RESIDENCE NO. 2145 Hollins ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of G. R. Albiker

6 DATE OF BIRTH (month, day, and year) Oct 29, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	66	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Engelhart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George R. Albiker
(Address) 2145 Hollins St

15 Filed MAY 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1924, to May 1, 1924, that I last saw her alive on May 1, 1924, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Enterolemn
1 hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Raymond Kalen, M. D.

5/2, 1924 (Address) 3027 Wood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 3 1924
20 UNDERTAKER George L. Schwab	ADDRESS 2161 Guilford Ave

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—10 Blks.

(St. Helena Cem. near P. R. R. Tracks)

D 86550

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86550

X196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Helena ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert B Kuhn

(a) RESIDENCE NO. 9187 Fayette ST., ... WARD Pittsburg Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Structural Iron Worker
(b) General nature of industry, business, or establishment in which employed (or employer) 079
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa.

PARENTS

10 NAME OF FATHER Grant Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lilly Irwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Margaret J. McClure
(Address) Bridgeton N.J. (Sister)

15 Filed MAY 3 - 1924, 192 Robert P. Harrison Registrar

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lung

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Rhodes M. D.
(Coroner)

5/2/24, 192 (Address) 123 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa — DATE OF BURIAL May 6 1924

20 UNDERTAKER Wm. J. Tichnor Sons — ADDRESS Mt Lebanon

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 8655E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 D 86551

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 S. Charles St ST., 23 WARD)

2-FULL NAME Catherine Berberich.

(a) RESIDENCE NO 1130 S. Charles St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widow.

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Joseph Berberich.

6 DATE OF BIRTH (month, day, and year) September 11, 1847.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Baltus Wagner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Kern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Kate Eisel. (daughter)
(Address) 1130 S. Charles Street.

15 Filed MAY 2 1924. 192 Robert [illegible]
Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of neck of femur.
Accidental fall down steps.

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Acute dilatation of the heart.

(duration) yrs. mos. ds.

(Signed) Otto M Reinhardt, M. D.
(Coroner.)

May 2, 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident

1130 S. Charles St April 7, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. Annap. Rd	May 3. 1924
20 UNDERTAKER	ADDRESS
Fred C. Krause & Son.	703 Hanover St

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Stevenson
2733 N. Charles St

Hosmd 5512

D 86552

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-00 D 86552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1710 Lakeside Ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alberta S Reiter

(a) Residence No. 1710 Lakeside Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Philip H Reiter

6-DATE OF BIRTH (month, day and year) July 29, 1867

7-AGE. 56 yrs. 9 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER. Edmund Robinson

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Md

12-MAIDEN NAME OF MOTHER. Emma L Walker

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country). Md

14- (Informant) Philip H Reiter
(Address) 1710 Lakeside Ave.

15- Filed MAY 3 1924 Robert P. Harrison, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 19 24 to May 1 1924, that I last saw h[e] alive on May 1 1924, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) yrs. 2 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No Physical examination findings

What test confirmed diagnosis?

(Signed) A M Stevenson, M. D.

5/V, 1924 (Address) 2733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount

DATE OF BURIAL. May 3, 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E Fayette Ave

A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A

Spec- 12-23-21-E.B.R.S.-400 Eks.

D 86553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1505 W. Lanvale St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Lanahan

(a) Residence No. 1505 W. Lanvale St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard

6-DATE OF BIRTH (month, day and year) Sept. 5 1853

7-AGE. 71 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James Dorsey

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Laura Dorsey

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland

14- (Informant) Mrs. Catherine Mahon

(Address) 1505 W. Lanvale

15- Filed MAY 3 - 1924 16-Robert P. Harris, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1922 to May 1 1924

That I last saw her alive on May 1 1924

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows: Old age

Senile Breakdown

of Mind & Body no

Special disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Not able to take Nourishment

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) C. E. Schmuck M. D.

May 5, 1924 (Address) 1007 N. Eutaw St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Mary's Woods	May 8, 1924
20-UNDERTAKER,	ADDRESS
Wm. Carr's Sons	1732 E. Fayette

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Burgle-
7554 Park Heights

D 86554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 86554

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 Park Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ora T Rigsan

(a) Residence No. 1427 Park Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ora T Rigsan

6-DATE OF BIRTH (month, day and year) Sept 27 1861

7-AGE. 63 yrs. mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos Fowler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Co Md

12-MAIDEN NAME OF MOTHER, Mary E Fowler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Co Md

14- (Informant) Howard Rigsan

(Address) 1427 Park Ave

15- Filed MAY 3 - 1924 19 Robert F. Garrison, Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 19 19, to May 1 19 24,

that I last saw h[illegible] alive on May 1 19 24,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

4

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D Gilbert M. D.

19 (Address) 4854 Park Heights Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn DATE OF BURIAL, May 3 1924

20-UNDERTAKER, Jno Cook & Son ADDRESS Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 3 - 1924

Spec.—1-10-21—M&T—1500 Bks.

D 86555

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86555

60-002

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

2-FULL NAME Sister Mrs. Dolores Swann

(a) RESIDENCE No. Dr. Frances Convent E. Chase St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister

(b) General nature of industry, business, or establishment in which employed (or employer) Religious Order

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mother M. Frances O.S.P
(Address) St Frances Convent E Chase St

15 Robert P. Harrison,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1924.

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1924. to May 1, 1924.
that I last saw her alive on April 30, 1924
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Toxic Adenomatous Thyroid.

(duration) yrs. 1/2 mos — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.
(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) B. W. S. Landes, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 4 1924
20 UNDERTAKER	ADDRESS
Mark A. Elliott	125 Cathedral

Spec.—1-10-21 M&T 1500 Bks.

D 86556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 86556

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) My. Gen Hospt ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Handy

(a) RESIDENCE No. 2013 Oak St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	35	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 670

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Geo Handy
(Address) 2013 Oak St

15 Filed 5-4 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1-1924

17 I HEREBY CERTIFY, That I attended deceased from 4-29-24 19.., to 5-1-24 19..,

that I last saw h.. alive on 5-1-24 19..,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Ch Endo Endocarditis ?

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema, Acute
Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Geo A Tompkins, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	5-4 1924
20 UNDERTAKER	ADDRESS
Joseph A. Farrell	2314 Division St

Spec–12-23-21–E.B.R.S.–400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86557

CERTIFICATE OF DEATH.

129

D 86557

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Pleasant Park Ave. Walbrook St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Martha Hind

(a) Residence No. Park & Wilson St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Hind

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. about 65 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

(c) Name of employer..... Colonel Deems

9-BIRTHPLACE (city or town)..... (State or Country), England.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Unknown

11- (Informant)..... Mrs. Harriet D. Black

(Address) 2604-36 Place N.W. West

15- Filed MAY 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 21924

17- I HEREBY CERTIFY, That I attended deceased from March 15th, 19 23, to May 2nd, 19 24, that I last saw her alive on May 1st, 19 24, and that death occurred, on the date stated above, at 1:15A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (chronic)
Chronic Interstitial Nephritis

3 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

1 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy. Diagnosis

(Signed) B. Silverhaun M. D

5/2 1924 (Address) 1901 Eutaw Place, City

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem.	May 3, 1924
20-UNDERTAKER. Wm Pickersons	ADDRESS. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86558

101-D 86558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2527 Fleet St., 1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frances Theisz

(a) Residence No. 2527 Fleet St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 25-1919

7-AGE.	If LESS than 1 day.
5 yrs. 1 mos. 7 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS:

10-NAME OF FATHER. Frederick Theisz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Mary Aires

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

11- (Informant) Mrs. Mary Theisz

(Address) 2527 Fleet St.

15- Filed MAY 3 - 1924 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 30 1924 to May 2 1924 that I last saw her alive on May 2 1924 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) None other

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. L. Loy, M. D.

5/2, 1924 (Address) 2701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
1st Evangelical Cem.	May 5, 1924
20-UNDERTAKER.	ADDRESS.
H. Sander Sons	1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86559

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 422 N. Chester St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Gombert

(a) Residence No. 422 N. Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Regina Gombert

6-DATE OF BIRTH (month, day and year): Aug. 20. 1843

7-AGE: 80 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Tailor
(b) General nature of Industry, business, or establishment in which employed (or employer): 080
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS:
10-NAME OF FATHER, Peter Gombert
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Gertrude Debilius
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Joseph Gombert
(Address) 422 N. Chester St

15-
Filed MAY 3 - 1924 19.. Robert E. Garrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 1. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 28 1924 to May 1 1924
that I last saw him alive on May 1 1924
and that death occurred, on the date stated above, at 6.15 P. M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bright's Disease

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

6/2 (Signed) Arthur E. Bloom M. D
, 1924 (Address) 3701 Fairmount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem	May 5 1924
20-UNDERTAKER, H. Sander Sons	ADDRESS 1710 Pleet St.

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86560 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 S. East Ave St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Taylor

(a) Residence No. 710 S. East Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert W. Taylor

6-DATE OF BIRTH (month, day and year) Oct 8. 1858

7-AGE. 65 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas H. Fletcher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary E. Collins

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Virginia

14- (Informant) Robert W. Taylor
(Address) 710 S. East Ave

15- Filed ..... 192.. ..... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 1. 1924

17- I HEREBY CERTIFY, That I attended deceased from March 4th 1924 to May 1st 1924 that I last saw her alive on May 1st 1924 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency / High Arterial Tension

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N. Athey M. D

May 2nd. 1924 (Address) 100 S. Patterson Parkway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem.	May 5th 1924
20-UNDERTAKER.	**ADDRESS.**
H. Lander Sons	1710 Pleasant St

Spec.—1-10-21—M&T—1500 Bks.

(Truxon)

D 86561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86561

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Edward Truxon

(a) RESIDENCE No. 729 N. Eden St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer H

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Truxon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Naomia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed MAY 3 1924, 19.. Robert F. Harrison, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to May 1, 1924.

that I last saw h[illegible] alive on May 1, 1924.

and that death occurred, on the date stated above, at 6 30 a.m.

The CAUSE OF DEATH was as follows:

Acute Secondary Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism Retro Pharyngeal Abscess

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bagg, M. D.

Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	May 3 1924
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1325 Gilmor St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86562

CERTIFICATE OF DEATH.

D 86562

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., No 90 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Wheary

(a) RESIDENCE NO. 522 S Chester ST., Ll WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Kate Wheary

6 DATE OF BIRTH (month, day, and year) Mch 30th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Balto.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Wheary

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Martha Reynolds

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 MAY 3 - 1924 Robert V. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to May 1, 1924, that I last saw h... alive on May 1, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Myocarditis Auricular Fibrillation Paroxysmal Ventricular Tachycardia Cardiac Hypertrophy Hydrothorax CPC

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Laurence Allen M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 5 1924
20 UNDERTAKER Lilly & Zeiler	ADDRESS 1538 W. Baltimore St

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86563

CERTIFICATE OF DEATH.

188-093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital WARD 7)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Almira I. Harris

(a) RESIDENCE NO. 828 N. Lakewood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) May 1st 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James D,.Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine M.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto.Md.

14 Informant James D.Harris
(Address) 828 N. Lakewood Ave

15 Filed MAY 3 - 1924, 192 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Autotruck injury-

(Inquest to be held)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. S. O'Connor, M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL May 3rd 1924

20 UNDERTAKER Lilly & Green ADDRESS 4033 Morgan

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86564

D 86564

CERTIFICATE OF DEATH.

Registered No. 109

1-PLACE OF DEATH

City of BALTIMORE: (No. 2406 E chase St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius C. Phelan

(a) Residence No. 2406 E chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) June 22-1906.

7-AGE. 18 yrs. 10 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Miller

(c) Name of employer Miller

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. albert Phelan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Peters

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Charles C. Peters

(Address) 2406 E. Chase St

15- Robert P. Harrison, Registrar.

MAY 3rd - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 29/24

17- I HEREBY CERTIFY, That I attended deceased from April 20 19 24 to April 29 19 24

that I last saw him alive on April 29 19 24

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Uremia Anuria

(Duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine examination

(Signed) Alma B Zimmerman M. D.

5/12/24 (Address) 718 N Gallows St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Paul Cemetery

DATE OF BURIAL, May 3 19 24

20-UNDERTAKER. Russ C. Miller

ADDRESS 2334 E Monument St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 86565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86565

CERTIFICATE OF DEATH.

90

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Oakdale Ave. near Philip St.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Gerlock.

(Residence in Baltimore: No. ~~3514 Dayette Place~~ Ponnell House

St.: 58 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct (Month) 18 (Day) 1858 (Year)

7-AGE,	If LESS than 1 day,
65 yrs. 6 mos. 17 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Annie Gheen

(Address) Oakdale Ave

15-

Filed MAY 3 - 1924, 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 1/24 (Month) (Day) (Year) 191...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular insufficiency (Cardiac)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Callan M. D. (Coroner.)

May 2/24 191... (Address) 508 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount Cemetery

DATE OF BURIAL, May 5, 1924

20-UNDERTAKER Chas C. Miller

ADDRESS 2334 Jefferson St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D 86566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86566

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 563 N. Calhoun ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Pfeffer

(a) RESIDENCE NO. 502 N. Calhoun ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W't	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Pfeffer

6 DATE OF BIRTH (month, day, and year) June 12 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) Work in Park

(c) Name of employer Bd. of City Commissioners

9 BIRTHPLACE (city or town) (State or country) Gettysburg Pa

PARENTS

10 NAME OF FATHER Geo. Pfeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs Robt. Megary
(Address) 502 N. Calhoun St

15 Filed MAY 3 - 1924, 19 ... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1924, to May 2nd, 1924,

that I last saw him alive on Apr. 30th, 1924,

and that death occurred, on the date stated above, at 6.22 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia Pellagra

(duration) Not known yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) ... yrs. 16 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Convulsions

(Signed) E. B. Smith, M. D.

5/2, 1924 (Address) 1605 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Cemetery Registered

DATE OF BURIAL May 4 1924

20 UNDERTAKER Josiah Syfert

ADDRESS 1605 W. North Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86567 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86567

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 3915 Belview St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Georgie Latham Cook

(a) Residence No. 3915 Belview St., 15 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 0 mos. 0 ds How long in U. S., if of foreign birth? 18 yrs. 8 mos. 8 ds.

DATA AN E... LY SO... AND EX... HEALTH NESTLY THANK

THIS IS A PERMANENT REC... ed EXACTLY. PHYSICIANS ...ed. Exact statement of OCC...

B.—WRITE PLAINLY, WITH UNFADING INK—THIS I... should be carefully supplied. AGE should be stated EX... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6-DATE OF BIRTH (month, day and year) Aug-23-1905

7-AGE. 18 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer). none

(c) Name of employer. none

9-BIRTHPLACE (city or town) (State or Country). Warrenton Virginia

PARENTS.

10-NAME OF FATHER. Richard H. Cook

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Emilene L. Fletcher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Warrenton Virginia

14- (Informant) Mr. R. H. Cook - Father

(Address) 3915 Belview Ave.

15- Filed MAY 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May-1-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to May 1, 1924

that I last saw h.e. alive on Apr. 30, 1924

and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 5 mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Statement X-Ray.

(Signed) Martin F. Sloan M. D.

5. 2, 1924 (Address) 415 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery

DATE OF BURIAL. May 3, 1924

20-UNDERTAKER. STEWART & BROWN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86568

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 934 S. Third St. ST.: 76 (WARD)

2-FULL NAME Joseph Clement Schultz

(a) RESIDENCE. NO. 934 S. Third St. ST., 76 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. If of foreign birth? 40 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Schultz

6 DATE OF BIRTH (month, day, and year) June 27-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Copper Works.

(c) Nome of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Clement Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Miss Mary Schultz. 934 S. Third St.

15 MAY 3 - 1924 , 19 . HARTIGAN, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I attended deceased from January 3rd, 1924, to May 1st, 1924, that I last saw h[illegible] alive on April 30th, 1924, and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Stone, M. D.

May 2, 1924 (Address) 1820 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: May 5 1924

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 4035 North Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86569

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D 86569

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Homewood Apartments

CITY OF BALTIMORE: (No. Charles + 31st Sts St.: 12th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Hughes Glidden

(a) RESIDENCE. NO. Homewood Apartments Charles + 31st ST.. 12 WARD. —

(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or ~~WIFE of~~) Pauline Boucher Glidden

6 DATE OF BIRTH (month, day, and year) April 15, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cleveland, Ohio U.S.A.

PARENTS

10 NAME OF FATHER Wm. Peirce Glidden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine, U.S.A.

12 MAIDEN NAME OF MOTHER Genevieve Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.A.

14 Informant Edward Hughes Glidden (Address) Homewood Apts Chas + 31st Sts

15 Filed MAY 3 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1924, to May 2, 1924 that I last saw him alive on May 2nd, 1924 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

5/3/1924 (Address) 3014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 5 1924
20 UNDERTAKER	ADDRESS 1532
George J Smith	Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86570 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 N Schroeder St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Alonzo Pitmond

(a) Residence No..... 19 N Schroeder St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. C

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 1905

7-AGE. 19 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Smithfield
(State or Country)..... Va

PARENTS.

10-NAME OF FATHER. Wm. Pitmond

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Va

12-MAIDEN NAME OF MOTHER. Rosie Ward

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Va

14- (Informant) Joseph Pitmond.
(Address) 19 N. Schroeder St

15- Filed MAY 3 - 1924 [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/1/24

17- I HEREBY CERTIFY, That I attended deceased from Apr 25, 19 24, to May 1, 19 24, that I last saw h... alive on May 1, 19 24, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Sparrow Point

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W J Norwood M. D.

May 3, 19 24 (Address) 919 Br Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Smithfield Va. DATE OF BURIAL, 5/3 19 24

20-UNDERTAKER. Mrs James H. Dennis ADDRESS 1803 Presstman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17 D 86571 — 34

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86571

5 161-004

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Edwin Schuman

(a) RESIDENCE NO. 345 N Gay St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 21, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... "

(c) Name of employer ..... "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Schuman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Lillie Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 MAY 3 - 1924 , 19 Robert T. Harrison Registrar

Vital Statistics Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1924, to May 2, 1924.

that I last saw h.. alive on May 2, 1924.

and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) Carlos Jackoff, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 3 1924
20 UNDERTAKER	ADDRESS
Edward W. Coulbourn	914 E. Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86572

CERTIFICATE OF DEATH.

5 - 90

D 86572

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 507 W. Eden St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James Cooper

(a) Residence No. 507 W. Eden St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 47 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 040

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Lewis Cooper

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Sophia Chase

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country),

14- (Informant) Nellie White

(Address) 507 W. Eden St

15- Filed MAY 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 1-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 9, 1923 to May 1, 1924

that I last saw h. alive on Apr 30, 1924

and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

1) Mitral Insufficiency

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Edward Fisher M. D.

5-1, 1924 (Address) 612 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Asbury Cemetery	May 4, 1924
20-UNDERTAKER.	ADDRESS
Mrs Chas G. Bailey	Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86573

CERTIFICATE OF DEATH.

D 86573

REGISTERED NO. 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. St., 8 WARD)

2-FULL NAME Helen Pfeifer

(a) RESIDENCE NO. 1836 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: William C. Pfeifer

6 DATE OF BIRTH (month, day, and year): March 11th 1901

7 AGE — Years: 23 — Months: 1 — Days: 21 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Adolph Mansperger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosenaldmansperger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William C. Pfeifer

(Address): 1836 N. Washington st

15 MAY 3 - 1924 19 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1924, to May 2, 1924, that I last saw her alive on May 2, 1924, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia 19

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Prolonged labor

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 4-28-24

Was there an autopsy? No

What test confirmed diagnosis? P.S. - Laboratory

(Signed) W. Jagielski, M. D.

19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: May 6 1924

20 UNDERTAKER: George E. Billinger & Sons — ADDRESS: 1126 Mount

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE ... should be stated EXACTLY. PHYSICIANS ... should state CAUSE OF DEATH in plain terms, so that it ... may be properly classified. Exact statement of OC... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86574

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Philadelphia Road ST., 76 WARD)

2-FULL NAME Bessie M. Smith

(a) RESIDENCE NO. 3503 Philadelphia ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of George W. W. Smith

6 DATE OF BIRTH (month, day, and year) Nov. 21st 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William H Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Margaret Hildebrandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant George W. W. Smith (Address) 3505 Philadelphia ave

15 Filed ....., 19.... Robert P. Harrison, Registrar

MAY 3 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to May 1, 1924, that I last saw her alive on April 20, 1924 and that death occurred, on the date stated above, at 10.40 a m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 1 hour

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E B Britton, M. D.

, 19 (Address) 1711 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 5 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1300 Greenmount Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86575 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86575

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1023 Ashland Ave St. 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Geo. Chappell

(a) Residence No. 1023 Ashland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6-DATE OF BIRTH (month, day and year) 1870

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work labor

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), m. d

PARENTS.

10-NAME OF FATHER, John W. Chapple

11-BIRTHPLACE OF FATHER (city or town) (State or Country), m. d

12-MAIDEN NAME OF MOTHER, Seale green

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), m. d

14- (Informant) John W. Chapple

(Address) 1216 Lamont ave

15- Filed Robert P. Harrison Registrar.

MAY 3 - 1924

Typical Female Plate

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Apr. 30/24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 24 19 24 to Apr. 30 19 24

that I last saw h[illegible] alive on Apr. 30 19 24

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Ex Endocarditis

(Duration) — yrs. 1 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Harold Wagner M. D.

5/1/24 (Address) 1001 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount cemetery

DATE OF BURIAL. May 4 1924

20-UNDERTAKER. Edward Bryan

ADDRESS 1631 Orleans St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86576 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

11621 D 86576

CERTIFICATE OF DEATH.

X 70 2 D 86576

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST., WARD)

2-FULL NAME Edith Rowe

(a) RESIDENCE NO. 703 Charlotte St ST., WARD Fredericksburg, Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
2	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER W. F. Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Chenery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL

15 MAY 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to May 3, 1924, that I last saw her alive on May 3, 1924, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Foreign Body in Bronchus

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Acute Laryngitis & Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/2/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. R Brugg M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va

DATE OF BURIAL May 3 1924

UNDERTAKER H Hankins & Co

ADDRESS Fredericksburg Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 86577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 86577

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1345 S. Mount St., 14 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Christian Leonard Krauss

(a) Residence No. 1345 S. Mount St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Carrie Lawrence Krauss

6-DATE OF BIRTH (month, day and year) July 1, 1872

7-AGE. 51 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plumber Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Singer Sewing Mach Co Washington D.C.

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER. Henry Krauss.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Katherine Schaffert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Mrs Carrie L. Krauss
(Address) 1345 S. Mound St

15- Filed MAY 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 15, 1923, to May 2, 1924

that I last saw living alive on May 1, 1924

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W. Jones M D

5.3, 1924 (Address) 222 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Rock Creek Cem — DATE OF BURIAL. May 5, 1924

20-UNDERTAKER. Wm Fickus & Son — ADDRESS North & Pa

MARGIN RESERVED FOR BINDING

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86578

CERTIFICATE OF DEATH.

D 86578

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

2-FULL NAME Ralph Stern

(a) RESIDENCE NO. Westminster Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse F. Stern

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Arndoff

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Joseph Stern
(Address) Westminster Md

15 Filed MAY 4 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 24

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1924, to May 3, 1924,

that I last saw him alive on May 3, 1924,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Compound Fracture Radius & Ulna (Lt) (Colles) 5 ds.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bacillus Aerogenes Capsulatus (Bacillus Aerogenes Capsulatus)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of April 28 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Saunderson, M. D.

19 (Address) Medical Surgical

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster St Johns	May 6 1924
20 UNDERTAKER H B Bankard & Son	ADDRESS Westminster Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86579

CERTIFICATE OF DEATH. X 100-001 ✓ D 86579

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 712 Bradley ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Bonam

(a) RESIDENCE NO. 712 Bradley ST., WARD Fla.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edon Bonam

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Valdosta Ga

PARENTS

10 NAME OF FATHER John Pelitz

11 BIRTHPLACE OF FATHER (city or town) Valdosta (State or country) Ga

12 MAIDEN NAME OF MOTHER Luna Pelland

13 BIRTHPLACE OF MOTHER (city or town) Valdosta (State or country) Ga

14 Informant E. Bonam (Address) 712 Bradley

15 MAY 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/24 1924

17 I HEREBY CERTIFY, That I attended deceased from apl 20, 1924, to apl 30, 1924, that I last saw h[illegible] alive on apl 30, 1924, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 856 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Palatka Flo. DATE OF BURIAL 5-5-1924

20 UNDERTAKER David Easton ADDRESS 916 Ea ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&S—100 Bks

1

D 86580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86580

CERTIFICATE OF DEATH.

25

1888

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

2-FULL NAME John Steinkraus.

(a) RESIDENCE NO 59 Third Ave. Wagner's Point. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. --- mos. --- dy. How long in U. S., if of foreign birth? 41 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~XXXXXXXXXXXX~~ HUSBAND of ~~XXXXXXXX~~ Augusta Steinkraus.

6 DATE OF BIRTH (month, day, and year) September 26, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor. 986
(b) General nature of industry, business, or establishment in which employed (or employer) Prudential Oil Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Henry Steinkraus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa. --------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Gustav Steinkraus (son)
(Address) Brooklyn Park Md.

15 Filed MAY 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd. 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Skull.
Struck by an automobile truck while walking along the road.
Accidental (duration) ... yrs. ... mos ... ds.
CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.
May 3rd. 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Bell Grove Inn Road. May 2nd. 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuels Cemet. DATE OF BURIAL May 4 1924

20 UNDERTAKER Louis Heimann ADDRESS 32 S Bro...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86581 | 3 | D 86581

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 2525 Eastern Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Augusta Duke

(a) Residence No..... 2525 Eastern Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 6/14/1875

7-AGE, 49 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Ged Duke

11-BIRTHPLACE OF FATHER (city or town)..... Saxony
(State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Steigmeyer

13-BIRTHPLACE OF MOTHER (city or town)..... Bavaria
(State or Country), Germany

14-

(Informant) Chas. A. Duke

(Address) 2525 Eastern Ave

15-

Filed..... 19..... ROBERT R. KRAUTER..... Registrar.

NOV 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 15th 1923 to May 3rd 1924

that I last saw her alive on May 2nd 1924

and that death occurred, on the date stated above, at 8-15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Tuberculous Laryngitis

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) F. A. Baldacci M. D.

, 19 (Address) 37 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel | DATE OF BURIAL, May 7, 1924

20-UNDERTAKER, Louis Heemann | ADDRESS 32 S Broad

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86582 ✓ D 86582

CERTIFICATE OF DEATH.

45

D 86582

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2028 Maryland Av St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary P. Jennings

(a) Residence No.... 2028 Maryland Av St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel

6-DATE OF BIRTH (month, day and year) April 27 1861

7-AGE.	If LESS than 1 day.
63 yrs. ..... mos. 5 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 0?

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, David Kinna

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Ireland Kinna

12-MAIDEN NAME OF MOTHER, Sarah Kinna

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland Kinna

14- (Informant) Mrs Dora Wantland

(Address) 442 W 23rd St

MAY 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb ....., 1923., to May 2 ....., 1924., that I last saw h. alive on May 1st ....., 1924., and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of the intestines

(Duration) 2 ? yrs. ..... mos. ..... ds.

CONTRIBUTORY.....

(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no Exam

What test confirmed diagnosis? only history & Inspection

(Signed) Fotenham R. Clarke M. D.

, 19 (Address) 1 St Johns Rd - Roland Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Mar 5	1924

20-UNDERTAKER.	ADDRESS
Wm Cook	502 E St - Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Gaddis 321 E. 25 ✓

D 86583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86583

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2709 Barclay St. St., 17 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. McGarvey

(a) Residence (No. 2709 Barclay St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Single Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 1903

7-AGE, 19 yrs. 10 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Upholster 1-25

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER, James McGarvey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Annie Riley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14-

(Informant) Hugh McGarvey

(Address) 2709 Barclay St.

15-

Filed ..... 19.. ROBERT R. KRAUTER Registrar.

MAY 4 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 15, 19 24, to May 2, 19 24,

that I last saw him alive on May 1, 19 24,

and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) H. W. Gardner, M. D.

5/3/24, 19 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL, May 5, 1924

20-UNDERTAKER, H. M. Cook — ADDRESS 502 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86584

CERTIFICATE OF DEATH.

D 86584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 N. Lanvale ST., 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Agnes D. Hook

(a) RESIDENCE NO. 1506 N. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard Hook

6 DATE OF BIRTH (month, day, and year) Apr 12/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	—	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Mt Washington
(State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Edward Donohue
11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)
12 MAIDEN NAME OF MOTHER Sadie Downey
13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs Mulloy
(Address) 1528 N. Lanvale st

15 Filed MAY 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 14, 1924, to May 3rd, 1924, that I last saw her alive on May 3rd, 1924, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis, with old Chronic Asthma. Now

(duration) ... yrs. ... mos. 2 / ... ds.

CONTRIBUTORY (Secondary) Dropsy Anasarca

(duration) ... yrs. ... mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Visible Hematuria

(Signed) E. L. Burrill, M. D.

5/0, 1924 (Address) 1609 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
D. C. Mercy's Grave Yard	May 6 1924
20 UNDERTAKER	ADDRESS
Wm Cook	902 E. Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86585

CERTIFICATE OF DEATH.

11-00 D 86585

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 Druid Hill Ave ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry J. Butler

(Residence in Baltimore: No. 2229 Druid Hill Ave St. 30 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH, Feb. (Month) 2d (Day), 1870 (Year)

7-AGE,	If LESS than 1 day,
54 yrs. 3 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter 10 0/0
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Butler

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Jane Bush

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Alice L. Butler, wife

(Address) 2229 Druid Hill Ave.

15-

Filed MAY 4 - 1924, 191.... ROBERT R. ....
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 3rd (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/12 1924, to 5/3 1924, that I saw h[e] alive on 5/2 1924 and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Influenza 4 d.

a. Metastasis

.....

..... (Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Anemia

..... (Duration) ....yrs. ....mos. 2 ds.

(Signed) Henry J. Butler M. D.

5/3, 1924 (Address) 2229 D. H. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mechanicsville, Md.	May 5..., 1924
20-UNDERTAKER J. W. T. Johnson	ADDRESS 1309 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Plymouth Road ST., Hamilton 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Lauder

(a) RESIDENCE NO. Plymouth Road ST., WARD 27th

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ward Lauder

6 DATE OF BIRTH (month, day, and year) Apr. 21. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	55	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Edw. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ward Lauder

(Address) Plymouth Road

15 MAY 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 2 1924

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to May 2, 1924,

that I last saw her alive on May 2, 1924,

and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Intestines

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tumor-

(Signed) E. H. Beelen, M. D.

5. 2. 1924 (Address) 1117 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 5 1924
20 UNDERTAKER	ADDRESS
D. S. Marshall	3538 Gall Ld

Spec.—1-10-21—M&T—1500 Bks.

D 86587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 86587

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S. East Ave ST., 1 WARD)

2-FULL NAME Harry Edward Brandau

(a) RESIDENCE NO. 226 S. East Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Caroline Brandau

6 DATE OF BIRTH (month, day, and year) June 16-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam + Electrical Eng.

(b) General nature of industry, business, or establishment in which employed (or employer) 830

(c) Name of employer B.C. + S. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward F. Brandau

11 BIRTHPLACE OF FATHER (city or town) Balto.,
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah E. Staub

13 BIRTHPLACE OF MOTHER (city or town) Balto.,
(State or country) Md.

14 Informant Caroline Brandau
(Address) 226 S. East Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
MAY 4 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1923, to May 2nd, 1924,
that I last saw him alive on May 2nd, 1924,
and that death occurred, on the date stated above, at 3.25 P. m.
The CAUSE OF DEATH* was as follows:
Cancer of the Urinary Bladder

(duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopic Examinations

(Signed) H. C. Landrock, M. D.

3, V, 1924 (Address) 1242 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 5 1924
20 UNDERTAKER Zurkler Zurkler	ADDRESS 1719 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—EiB.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86588

CERTIFICATE OF DEATH.

D 86588

6 90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 140 N. Streeper St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgama Williams

(a) Residence No. 140 N. Streeper St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michall Williams

6-DATE OF BIRTH (month, day and year) April 28 1846

7-AGE ..78.. yrs. ..4.. mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..None..

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Dorfus Reynolds

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14- (Informant) Charles Weitzel

(Address) 140 N. Streeper St.

15- Filed MAY 4 - 1924 ROBERT. R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2 - 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1924 to May 1st 1924

that I last saw h.. alive on May 1st 1924

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 1 yr. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert T. Kirk M. D.

5/3 1924 (Address) 3126 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Int. Carmel	May 5 1924
20-UNDERTAKER Zurkler & Zurkler	ADDRESS 1234 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86589

CERTIFICATE OF DEATH.

90

D 86589

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1827 E. Lafayette Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Hart

(a) RESIDENCE NO. 1827 E. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas L. Hart

6 DATE OF BIRTH (month, day, and year) Dec 28, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Laurence Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie E. Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Nicholas L. Hart

(Address) 1827 E. Lafayette Ave

Filed MAY 4 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to May 2, 1924

that I last saw him alive on May 2, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) [illegible] M. D.

May 3, 1924 (Address) 1827 E. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland

DATE OF BURIAL May 5 1924

20 UNDERTAKER Zurkler & Zurkler

ADDRESS 109 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86590

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2700 Fenwick ave ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bahlke

(a) RESIDENCE NO. 2700 Fenwick ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bahlke

6 DATE OF BIRTH (month, day, and year) May 5, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Building Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) Brunswick Bahlke Bldg

(c) Name of employer Berlin

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Bahlke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George W. Bahlke (Address) 6 Talbot Rd.

15 Filed ... 19 ... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to May 3, 1924.

that I last saw h[illegible] alive on May 3, 1924.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary) Hypostatic congestion

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. J. Davis M. D.

19 (Address) 500 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL May 7 1924

UNDERTAKER Burkert & Burkert

ADDRESS 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86591

CERTIFICATE OF DEATH.

X 44

D 86591

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Gavin

(a) RESIDENCE NO. St. George, S. C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Chas. M. Gavin

6 DATE OF BIRTH (month, day, and year) Sept 6, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER William Gavin

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER — —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Interment Hospital Records (Address)

15 MAY 4 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to May 4, 1924, that I last saw him alive on May 4, 1924 and that death occurred, on the date stated above, at 12.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in South Carolina

Did an operation precede death? Yes Date of April 28, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. B. Price M. D.

May 4. 1924 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. George S.C.	May 6 1924
20 UNDERTAKER	ADDRESS
Harry N. Witzke	1531 W. Lombard St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86592

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-007 D 86592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Forrest Place St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. King

(a) Residence No. 1105 Forrest Place St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓ ✓ ✓

6-DATE OF BIRTH (month, day and year): Unknown 1874

7-AGE: 50 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: John King

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Catherine Toner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14 (Informant): Chas. K. Wood

(Address): 1105 Forrest Place

MAY 4 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 3-1924

17- I HEREBY CERTIFY, That I attended deceased from 3/27 19 24 to 5/3 19 24

that I last saw h.. alive on 5/2 19 24

and that death occurred, on the date stated above, at 12 09 A.M.

The CAUSE OF DEATH* was as follows:

Hodgkins disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of lungs

(Duration) 1 wk. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam of gland

(Signed) Dr Bernard Wolff, M. D.

5/3, 19 24 (Address) 914 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 5/6 19 24

20-UNDERTAKER: Chas. F. Brauer & Son

ADDRESS: 1128 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86593

CERTIFICATE OF DEATH.

129 D 86593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2318 Orleans St. ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Alice Melson

(a) RESIDENCE No. 2318 Orleans St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
(or) WIFE of Mathis Melson

6 DATE OF BIRTH (month, day, and year) May 8th. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Chance
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Scott

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Windsor

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Lucy Sims
(Address) 506 N Robinson St.

15 Filed MAY 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd. 1924

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 24 to May 3 , 19 24

that I last saw her alive on May 3 , 19 24

and that death occurred, on the date stated above, at 6:40 P.Mm.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 4 hrs

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Ralph L Voght, M. D.

, 19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Princes Anna Somerset Co. Md.	5/6/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86594

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Bolton 2nd St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Johnson

(a) RESIDENCE NO. 10 N. Bolton St., Ward New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver Johnson

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Edw. Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Martha Sando

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Hospital Records

(Address)

Filed MAY 4 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/1924

17

I HEREBY CERTIFY, That I attended deceased from 4/25/1924, to 5/3/1924.

that I last saw h alive on 5/2/1924

and that death occurred, on the date stated above, at 2 15 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Godley, M. D.

. 19 (Address) Mercy

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: May 8 1924

20 UNDERTAKER: Jos. J. H. Rochester — ADDRESS: 1439 Jefferson St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86595

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86595

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3048 W. North Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Ward

(a) Residence No. 3048 W. North Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Yates Ward

6-DATE OF BIRTH (month, day and year) June 5, 1850

7-AGE.	If LESS than 1 day.
73 yrs. 10 mos. 27 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, James Houston

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Helen Carruthers

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country), Maryland

14- (Informant) Richard Y. Ward
(Address) 3048 W. North Ave.

15- MAY 5 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/2/24

17- I HEREBY CERTIFY, That I attended deceased from May 16 1917, to May 2" 1924, that I last saw her alive on May 2" 1924, and that death occurred, on the date stated above, at 9.20 P.M.

The CAUSE OF DEATH* was as follows:

Mitral and Aortic Regurgitation and Stenosis

(Duration) 6 yrs. 11 mos. 22 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 6 mos. 4 ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Herbert E. Fesh M. D

5/7, 1924 (Address) 3048 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cemetery	5/5, 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

92

1715 D 86596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86596

CERTIFICATE OF DEATH.

23

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 8 WARD)

2-FULL NAME Agnes Burke

(a) RESIDENCE NO. 1718 Preston St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Teresa Gelgone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Thomas Burke.

(Address) 1742 E Preston St

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1924, to May 2, 1924.

that I last saw her alive on May 2, 1924.

and that death occurred, on the date stated above, at 1.00 a. m.

THE CAUSE OF DEATH was as follows:*

Epidemic Encephalitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R Bunting M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys. Govans.	5/5/1924

20 UNDERTAKER ..... ADDRESS

E. J Fanning & Son 1938 E Lafayette av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86597

CERTIFICATE OF DEATH.

129 D 86597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1351 N. Stricker ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Hill.

(a) RESIDENCE NO. 1351 N. Stricker ST., WARD

(Usual place of abode) (If noo-resident give city or towo and State)

Length of residence in city or town where death occurred 71 yrs. 1 mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin Hill.

6 DATE OF BIRTH (month, day, and year): April 2nd. 1853

7 AGE: Years 71 — Months 1 — Days 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home. 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Anne Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Amanda Hill. (Address) 1351 N. Stricker St.

15 MAY 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 26, 1924, to May 2, 1924, that I last saw h alive on May 1, 1924 and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

1 Chronic Interstitial Nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine

(Signed) Harry F Brown, M. D.

5/3 1924 (Address) 1351 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: May 5th 1924

20 UNDERTAKER: A. Jones

ADDRESS: 111 S. Gilmor St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86598

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2809 Eastern ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... William French

(a) Residence No. 2809 Eastern St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND ~~of (or) WIFE of~~ Carrie French

6-DATE OF BIRTH (month, day and year) April 12th 1886

7-AGE: 38 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer): 063

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Carrie French

(Address) 2809 Eastern ave.

15- Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 5-2-24

17- I HEREBY CERTIFY, That I attended deceased from 4-20, 1924, to 5-2, 1924, that I last saw h... alive on 5-2, 1924, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculosis of Larynx

(Duration) ... yrs. 6 mos. ... ds.

18-Where was disease contracted if not at place of death? ..... Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) ... M. D.

4-..., 1924 (Address) 500 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — DATE OF BURIAL: May 5th 1924

20-UNDERTAKER: J J Moran — ADDRESS 300 E Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86599

D 86599

CERTIFICATE OF DEATH.

84

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3030 E. Baltimore St ST., 6 WARD)

2-FULL NAME Hannah Waldo

(a) RESIDENCE No. 3030 E Baltimore St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	7	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Charles W. Waldo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticut

12 MAIDEN NAME OF MOTHER Elizabeth Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Charles H. Moore

(Address) 3030 E Balto St.

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25- 1924, to May 2 1924,

that I last saw her alive on May 1- 1924,

and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain,

Probably in Right Parietal Lobe.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen C. Beetham, M. D.

5-2, 1924 (Address) 3139 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 5th 1924
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore St.

Cor.—1-12-23—M&T—100 Bks.

D 86600

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 86600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 W. Cullen St., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith Bynum

(a) RESIDENCE NO. 909 W. Cullen St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Bynum

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Turner

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Fannie Bynum
(Address) 909 W. Cullen St.

15 Filed MAY 5 - 1924 ROBERT R. KRAUTH Burial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronch-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) D. J. Hennessy, M. D.
(Coroner.)

May 4, 1924 (Address) 201 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 5 1924
20 UNDERTAKER John H. Scudder	ADDRESS 1423 Usher St

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PRESS FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86601

D 86601

123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura L Dawson

(a) RESIDENCE NO. 4506 Wetzel Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Dec 7th 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER Richard Sutton

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Roscellina Chilton

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant John Dawson

(Address) 3[illegible] Richmond Ave

MAY 5 - 1924

ROBERT R. KRAUTH, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to May 2, 1924, that I last saw her alive on May 2 1924, and that death occurred, on the date stated above, at 6 45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Terminal Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & hypertension

Chr. Endocarditis (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4506 Wetzel Ave

Did an operation precede death? yes Date of April 25 24

Was there an autopsy? No. Hypostatic

What test confirmed diagnosis? Usual evidence

(Signed) Geo B Seybert, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 5th 1924
20 UNDERTAKER	ADDRESS
Johannah Eandes	1004 Aisquith St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86602

CERTIFICATE OF DEATH.

129 D 86602

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Myrtle Place ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Meyer

(a) RESIDENCE No. 3409 Myrtle Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ludwig H. Meyer

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not employed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Bothe

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Regine Kropp

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Ludwig Meyer
(Address) 3409 Myrtle Place

MAY 5 - 1924

Filed , 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1924, to May 3, 1924.

that I last saw her alive on May 3, 1924

and that death occurred, on the date stated above, at 10 40 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Lucien V. Loskot, M. D.

, 19 (Address) 845 N. Patterson Pk. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 6. 1924
20 UNDERTAKER	ADDRESS
Chas C. Miller	2334 Gilmor

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86603

D 86603

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 Lanvale St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Taylor Hamilton

(a) Residence No. 618 Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower

6-DATE OF BIRTH (month, day and year): June 20-1854

7-AGE: 69 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired 051

(b) General nature of Industry, business, or establishment in which employed (or employer): Plasterer

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore (State or Country): Md

PARENTS.

10-NAME OF FATHER: John Hamilton

11-BIRTHPLACE OF FATHER (city or town): (State or Country): Gov. York

12-MAIDEN NAME OF MOTHER: Don't Know

13-BIRTHPLACE OF MOTHER (city or town): (State or Country): Don't Know

14- (Informant): Mrs Harry F. Gaul

(Address): 618 Lanvale St.

15- MAY 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 3rd-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 31, 1924, to May 3, 1924, that I last saw h-- alive on May 3, 1924, and that death occurred, on the date stated above, at 12-35 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

4

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinic & History

(Signed) James Brown, M. D.

5/3, 1924 (Address) 1837 Pine ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 5/5/24, 19....

20-UNDERTAKER: Geo Weber Son — ADDRESS: 2503 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-601

D 86604

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Linden Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas U. Conner

(a) RESIDENCE NO. 1801 Linden Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine McCormick Conner

6 DATE OF BIRTH (month, day, and year) Dec 15 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Thomas U. Conner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Gene. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant H. M. McCormick
(Address) Homewood Apts

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to May 3, 1924.

that I last saw h.. alive on May 3-6 Am, 1924

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Type IV

..... (duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Coma

..... (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) W. S. Love, M. D.

, 19 (Address) 536 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 5 1924

20 UNDERTAKER Chas. Ottenstedt ADDRESS 120 W. Fayette St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86605

CERTIFICATE OF DEATH.

135 D 86605

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1429 N. Fayette St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph R. Wynn

(a) Residence No. 1429 N. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emily Gould Wynn

6-DATE OF BIRTH (month, day and year) Dec. 23-1832

7-AGE. 91 yrs. 4 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER Christopher Wynn

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Ann Ashley

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country),

14-

(Informant) Ella W. King

(Address) 243 Mt Royal Ave

MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 3/24

17- I HEREBY CERTIFY, That I attended deceased from April 10, 19 24, to May 3, 19 24,

that I last saw him alive on May 3, 19 24,

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Enlarged Prostate

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) John A Geary M. D.

, 19 (Address) 501 E. Eager

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. May 5 19 24

20-UNDERTAKER. John O. Whitelaw — ADDRESS 201 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 86606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 86606

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1826 Edmondson Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Miller Jr.

(a) Residence No. 1826 Edmondson Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of single

6-DATE OF BIRTH (month, day and year) Feb 4. 1839

7-AGE. 85 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto Md
(State or Country).

PARENTS.

10-NAME OF FATHER, Wm. D. Miller

11-BIRTHPLACE OF FATHER (city or town)... Balto
(State or Country), Md

12-MAIDEN NAME OF MOTHER, Helen A. Troop

13-BIRTHPLACE OF MOTHER (city or town) Scotland
(State or Country),

14- (Informant) Helen M. Crouse

(Address) 1826 Edmondson ave

15- Filed MAY 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2/24

17- I HEREBY CERTIFY, That I attended deceased from Apr 25 1924 to May 2 1924

that I last saw h.r alive on May 2 1924

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Heart Disease

(Duration) ....yrs. 4 mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) J. T. Nelson M. D.

, 19 (Address) 1300 Boston

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount — DATE OF BURIAL, May 5 1924

20-UNDERTAKER, John O'Meara — ADDRESS 120 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Martha M Turner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86607

CERTIFICATE OF DEATH.

109-002

D 86607

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Archer ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Coretta May Turner

(a) RESIDENCE. No. 633 Archer ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colo	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 26 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER May Ringgold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Walter Turner
(Address) 633 Archer

15 MAY 5 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 26, 1924, to May 2, 1924, that I last saw her alive on May 2, 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
(Following Acute Tonsilitis)
(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. H. Carroll, M. D.

5/4/, 19 (Address) 1400 W Fed St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	May 5 1924
20 UNDERTAKER	ADDRESS
S. R. Brown & Son	108 N Monty-e

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Ellel Sjokorsb

D 86608

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101-001 D 86608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S Marine Hosp ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellel Sjokvist

(a) RESIDENCE NO. 211 S- Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unkn mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer USN

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant U S Marine Hosp. Balto Md

(Address)

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/3 1924 to 5/4 1924

that I last saw him alive on 5/4 1924

and that death occurred, on the date stated above, at 11,20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Bilateral

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 211 E- Eden St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical exam

(Signed) M. N. F. otter M. D.

5/5/24 Marine Hospital Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL 5/5 1924

20 UNDERTAKER Lemmon & Sons — ADDRESS 112 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 38 D 86609

1-PLACE OF DEATH U.S. Marine Hospital #1 Baltimore, Md.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME George Jackson.

(a) RESIDENCE NO. U.S. Marine Hospital No 1 ST., ... WARD .....

(Usual place of abode) Baltimore Md.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Un known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Sch. Mary Richard 086 Un known

9 BIRTHPLACE (city or town) (State or country) .....

PARENTS

10 NAME OF FATHER Un known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un known

12 MAIDEN NAME OF MOTHER Un known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Un known.

14 Informant U.S. M. Hosp No 1 (Address)

15 Filed MAY 5 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17

I HEREBY CERTIFY, That I attended deceased from May 1 —, 1924, to May 2, 1924.

that I last saw him alive on May 2, 1924,

and that death occurred, on the date stated above, at 12 15 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis, acute Haemorragica

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dy Influenza.

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Un known

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory & Clinical

(Signed) M. X. Foster M. D.

5/3. 1924 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	5/4 1924
20 UNDERTAKER Sol. Levinson.	ADDRESS 1127 E Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86610 ✓ D 86610

CERTIFICATE OF DEATH.

D 86610

1-PLACE OF DEATH

Registered No. 161-002

City of BALTIMORE: (No.) 504 N. Streeper St., (Ward) 7

2-FULL NAME Child of John P. + Pearl D. Metzger

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 504 N. Streeper St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 4/24

7-AGE ✓ yrs. mos. ds. If LESS than 1 day, 2 hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, John P. Metzger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Pearl D Meekins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) John P. Metzger

(Address) 504 N. Streeper

MAY 5 - 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 4/24

17- I HEREBY CERTIFY, That I attended deceased from May 4 1924 to May 4 1924

that I last saw h[illegible] alive on May 4 1924

and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Surgery of Bladder

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D

May 4, 1924 (Address) 1901 Garrison Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltolem.	May 5, 1924
20-UNDERTAKER. Philip Henry	ADDRESS 506 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86611

CERTIFICATE OF DEATH.

D 86611

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Holbrook ST., 9 WARD)

2-FULL NAME Josephina C Guckert

(a) RESIDENCE NO. 1416 Holbrook ST., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Guckert Sr

6 DATE OF BIRTH (month, day, and year) March 10 1838

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
86	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bath

PARENTS

10 NAME OF FATHER Friedrich Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Guckert
(Address) 1416 Holbrook

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to May 2, 1924.

that I last saw h.. alive on May 2, 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. S. Thomas M. D.

May 6 1924 (Address) 1228 W Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	May 6 1924
20 UNDERTAKER	ADDRESS
Wendell Piffel & Son	378 Mn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 86612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Paul

(a) RESIDENCE NO. 408 Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4/4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) Aug 9 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balt & Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Paul

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Matthews

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Hospital Record.
(Address)

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2 1924, to May 3 1924,

that I last saw h— alive on May 3 1924,

and that death occurred, on the date stated above, at 9.20 m.

The CAUSE OF DEATH* was as follows:

Acute Inanition
Probably.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. W. Hollar, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	May 6 24
20 UNDERTAKER	ADDRESS
Fred'k Irby Fulton	Baltimore

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 2500 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Elizabeth Stallo

(a) Residence No. 323 Harlem Lane St., (Catonsville) Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR ~~OR RACE~~, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 12 1868

7-AGE 55 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Md. Baltimore

PARENTS.

10-NAME OF FATHER. John Bush.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Mary Reth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md.

14- (Informant) Geo Stallo

(Address) 323 Harlem Lane Catonsville

15- Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2-24

17- I HEREBY CERTIFY, That I attended deceased from April 17- 1924, to May 2 1924, that I last saw h-e alive on May 2 1924, and that death occurred, on the date stated above, at 8 am m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Idg

(Signed) H V Harper, M. D.

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Holy Cross A A Co	5-6..., 1924
20-UNDERTAKER,	**ADDRESS**
E & B Hark	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86614

CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO. D 86614

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Duncan ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Butler Jr.

(a) RESIDENCE NO. 509 N Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850 exact date unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Cora Davis (Address) 510 N. Duncan st

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1924, to May 3, 1924, that I last saw h[illegible] alive on May 2, 1924, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis about 3 yrs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Lab.

(Signed) R J Gatchell, M. D.

5/6, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	may 5 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86615 CERTIFICATE OF DEATH. 139 D 86615

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Cross

(a) RESIDENCE No. 4109 Walnut Ave ST., Balto. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar Cross

6 DATE OF BIRTH (month, day, and year) Feb 2nd 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Edward Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah McAffee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edgar Cross. (Address) 4109 Walnut Ave.

15 Filed MAY 5 - 1924 19... ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 4, 1924, that I last saw her alive on May 4, 1924, and that death occurred, on the date stated above, at 3.24 a.m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid
Abdominal Adhesions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 3/24

Was there an autopsy? No.

What test confirmed diagnosis? Operative Findings

(Signed) R. H. Slaughter, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 7 1924
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Eutaw St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86616 **CERTIFICATE OF DEATH.** 19 129 D 86616

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 132 S. Carey St. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Beck

(a) Residence No. 132 S. Carey St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Beck

6-DATE OF BIRTH (month, day and year) May 12, 1848

7-AGE. 75 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Bingel

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eva Schwinn

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Harry A. Richardson

(Address) 309 S. Calhoun St.

15- Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from 3/9/24, 19..... to 5/2/24, 19....., that I last saw h.. alive on 5/1/24, 19....., and that death occurred, on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ch. Int. Nephritis

(Duration) yrs. ? mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. E. Wenneker, M. D.

5-2-, 1924 (Address) 1302 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park Cem.	May 5th, 19 24
20-UNDERTAKER.	**ADDRESS**
Joseph B. Cook	1003 W. Lafayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86617

CERTIFICATE OF DEATH.

D 86617

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1717 W. Baltimore St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Louis A. & Catherine T. Buchheit

(a) Residence No. 1717 W. Baltimore St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Singl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 3, 1924

7-AGE	If LESS than 1 day,
..... yrs. ..... mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Louis A. Buchheit

11-BIRTHPLACE OF FATHER (city or town)..... Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Catherine T. Leibig

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore
(State or Country), Maryland

11

(Informant)..... Louis A. Buchheit

(Address)..... 1717 W. Baltimore St.....

15

MAY 5 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 3, 1924 to May 3 19 24

that I last saw h.. alive on May 3 19 24

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Holland Keech M. D.

5-3-1924 (Address) 305 N. Calhoun Street

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. | DATE OF BURIAL, May 5, 1924

20-UNDERTAKER, Ralph B. Cook | ADDRESS 1003 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86618

CERTIFICATE OF DEATH.

X 11 7 D 86618

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) St. Joseph's Hospital St. 9 WARD)

2-FULL NAME Margaret E. Kelly

(a) RESIDENCE No. York Road, Towson ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? 25 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick J.Kelly

6 DATE OF BIRTH (month, day, and year) Dec.12,1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
41	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick J.Kelly

(Address) Towson,Maryland

15 Filed MAY 5 - 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1924, to May 1, 1924

that I last saw her alive on May 1, 1924

and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Lobar pneumonia

(Duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cholecystitis & Cholelithiasis

Chronic Appendicitis (Duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Towson, Md.

Did an operation precede death? Yes Date of April 29

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Sybert M. D.

(Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL May 5 1924

20 UNDERTAKER Joseph L. Cook

ADDRESS 1003 W Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86619

CERTIFICATE OF DEATH.

90 D 86619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Hanover St. ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary L. Lawton.

(a) RESIDENCE No 1110 Hanover St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. ——— mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced (or) WIFE of Richard Lawton.

6 DATE OF BIRTH (month, day, and year) October 24, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10 NAME OF FATHER James M. Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Ellen Hooker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant James W? Lawton. (son)
(Address) 1110 Hanover St.

15 Filed MAY 5 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd. 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto H. Reinhardt, M. D. (Coroner.)

May 3rd. 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	May 6 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86620

CERTIFICATE OF DEATH.

179 D 86620

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Sanders ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James D Fisher

(a) RESIDENCE No. 406 Sanders ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E Fisher

6 DATE OF BIRTH (month, day, and year) July 13 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	80	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 015

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Caulker

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth Ramey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Thomas K. Fisher (Address) 406 Sanders St

15 Filed MAY 5 - 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 30, 1924, to May 2, 1924, that I last saw him alive on May 2, 1924, and that death occurred, on the date stated above, at 9 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Not

(Signed) M L E Stifler, M. D.

5/5, 1924 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 5 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D 86621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86621

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James G. Winters

(a) RESIDENCE No. 125 East Virginia Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 069

(b) General nature of industry, business, or establishment in which employed (or employer) Postal Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jacob H. Winters

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elvira E Lewis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Jacob H. Winters Jr (Address) 5001 Liberty Heights Ave

15 MAY 5 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 24

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to May 4, 1924, that I last saw h— alive on May 4, 1924, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Pan Sinusitis

Osteomyelitis Frontal Bone

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute Infection Pneumonia (Streptococcus)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes Clinical

What test confirmed diagnosis?

(Signed) James Corbett Wilkerson M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL May 7 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86622

CERTIFICATE OF DEATH.

161-001 D 86622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1166 Sargeant ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Siegel

(a) RESIDENCE NO. 1166 Sargeant ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 19, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Baltimore,
(State or country) ..... Md.

PARENTS

10 NAME OF FATHER Maurice Siegel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Legg

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Dorothy Legg.
(Address) 1166 Sargeant St

Filed MAY 5 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1924, to May 3, 1924,

that I last saw h.. alive on " ", 1924,

and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows:

Prematurity

Malnutrition

..... (duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Dr. J. Coolahan M. D.

5/5, 1924 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL May 5 1924

20 UNDERTAKER John J. Cannon & Son

ADDRESS 301 Hollins

per J. J. Cannon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86623 ✓ 11-001 D 86623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Washington Blvd (Brooklyn) ST., 2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex Kronsteiner

(a) RESIDENCE NO. Washington Blvd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kronsteiner

6 DATE OF BIRTH (month, day, and year) June 7-1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Str

(c) Name of employer S. Balto Car Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alex J. Kronsteiner

(Address) Wash'n & 2nd ave Brooklyn

15 Filed ....., 19..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MAY 5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1924, to May 1 — 1924.

That I last saw him alive on Apr 30 1924

and that death occurred, on the date stated above, at 10 — m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

— (duration) ... yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Supposed

(Signed) A. Glueck, M. D.

, 19 (Address) 1340 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL May 5 1924

20 UNDERTAKER F. A. Krause & Son

ADDRESS 703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86624

86624

CERTIFICATE OF DEATH.

129 2

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1713 Eastern Avenue St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jacenty Spioch .....

(a) Residence No. 1713 Eastern Avenue St., ... Ward 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sep. 10 1863

7-AGE. 60 yrs. 7 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Poland ..... (State or Country).

PARENTS.

10-NAME OF FATHER, James Spioch

11-BIRTHPLACE OF FATHER (city or town)..... Poland ..... (State or Country).

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Poland ..... (State or Country).

11- (Informant) Mrs Lena Jankiewicz

(Address) 1713 Eastern Avenue

Filed MAY 5 - 1924 192... ROBERT R. KRAUICh, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 3 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1922, to May 3 1924,

that I last saw h.. alive on May 3 1924,

and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) ..... yrs. unknown

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr A Jamrozinski M. D.

5/5, 1924 (Address) 241 Fait Av.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	May 6 1924

20-UNDERTAKER,	ADDRESS
John M Weber	1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Tebbs

D 86625

HEALTH DEPARTMENT—CITY OF BALTIMORE

1500 D 86625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 Eutaw Pl. ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burly Tebbs

(a) RESIDENCE NO. 1931 Eutaw Pl. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/24/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	9 mo.	7 da.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Robert P. Tebbs

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Rachel Wilburn

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant

(Address)

MAY 5 - 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 19

17 I HEREBY CERTIFY, That I attended deceased from 4/24, 19 . to 4/24/24 . 19 .

that I last saw h alive on 4/24 . 19 .

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

4/25, 19 (Address) 1120 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Draper & Powers.	ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 86626

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1911 Christian St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. Green

(a) Residence No. 1911 Christian St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maria C. Green

6-DATE OF BIRTH (month, day and year) Feb. 28- 1849

7-AGE. 75 yrs. 2 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Porter in

(c) Name of employer..... wholesale house

9-BIRTHPLACE (city or town) (State or Country), A.A.Co. Md.

PARENTS.

10-NAME OF FATHER, Unkown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- (Informant) Mrs. Maria C. Green

(Address) 1911 Christian St.

15- MAY 5 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 4th 24

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to May 3 1924

that I last saw h.m alive on May 3 1924

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

chronic interstitial Nephritis

uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D

5.5. 1924 (Address) 571 Fallsway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
MT. Auburn	May 7th. 1924
20-UNDERTAKER.	**ADDRESS**
George L. Schwab	2101 Fredk. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86627

CERTIFICATE OF DEATH.

162 D 86627

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 - E Fayette ST.: 5 WARD)

2-FULL NAME Standford Johnson

(a) RESIDENCE. NO. 1411 - E - Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 22nd 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER P. A. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Pauline Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanley A.A.Co.

14 Informant Rudolphus Hall

(Address) Marley A.A.Co Md

15 Filed MAY 5 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 22, 1924, to May 4, 1924,

that I last saw h— alive on May 2, 1924,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Umbilical Peritonitis.

.....(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) P. A. Johnson M. D.

, 19 (Address) 2411 - E - 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Cem	5/5 1924

20 UNDERTAKER ADDRESS

Jas. M. Kimmel 1022 E. Madison St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 86628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Orlando & Lipple Aves. ST., Hamilton WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Reidhardt

(a) RESIDENCE No. Harford Road & Maple Aves. ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Reidhardt

6 DATE OF BIRTH (month, day, and year) Sept 25th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of Industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Fred. Reidhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Catherine Posey (Address) Hamilton Md.

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4 1923 to May 3 1924 that I last saw him alive on May 3 1924 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B Green, M. D.

5/4. 1924 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cemetery — DATE OF BURIAL May 6 1924

20 UNDERTAKER Fredk Lassahn Sons — ADDRESS Fullerton

Spec. 12-23-21—E.B.R.S.—400 Bks.

Lamatewitz

29 86629

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-901 D 86629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 407 Arundel ave Bay View St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H. Lamatewitz

(a) Residence No. 407 Arundel ave St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? —yrs. —mos. —ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the Word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) Mary A Lamatewitz

6-DATE OF BIRTH (month, day and year) June 21st 1878

7-AGE: 45 yrs. 10 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Balto. Md

PARENTS

10-NAME OF FATHER: Chas. J Lamatewitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Charlotte Brandt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-INFORMANT: Henry Lamatewitz
(Address) 905 S. Bentalou St

15-

ROBERT R. KRAUTER
Burial Permit Clerk.

MAY 5 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 2 1924

17- I HEREBY CERTIFY, That I attended deceased from April 22 1924 to May 2 1924.

that I last saw him alive on May 2 1924

and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Tetanus Ommmm

(Duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. P. Watson M. D.

, 19 (Address) 827 N. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 5th 1924

20-UNDERTAKER: H. B. Kryger

ADDRESS 2336 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86630 CERTIFICATE OF DEATH. 66 D 86630

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Wallace

(a) Residence No. Baltimore City Jail St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1878

7-AGE,	If LESS than 1 day,
46 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 154

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

11-Informant Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15-Filed MAY 5 - 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-1-24

17- I HEREBY CERTIFY, That I attended deceased from 4-28, 1924, to 5-1, 1924

that I last saw h~~im~~ alive on 5-1, 1924

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

Chronic Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY Broncho-Pneumonia

(Secondary)

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Tab

(Signed) Claude S. Drake M. D.

5-1, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
	19....

20-UNDERTAKER Commissioner Health. ADDRESS MAY 3 - 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

140

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86631 — 162 — D 86631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3233 E Baltimore St.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Hunt

(Residence in Baltimore: No. 3233 E Baltimore St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. May 2, 1924 (Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Samuel Hunt

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Carrie Claybaugh

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

MAY 5 - 1924 ROBERT R. KRAUTER, ..., 191... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 3, 1924 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 2 1924, to May 3 1924, that I saw h[illegible] alive on May 3 1924, and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Maynard L. Magruder M. D.

5/3/24, 191... (Address) 3115 E Baltimore St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, State Bond. Dr Rohrer — DATE OF BURIAL, ..., 191...

20-UNDERTAKER Commissioner Health. — ADDRESS MAY 4 - 192[illegible]

Per. Jno. E. WOODALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

140

Spec.—1-10-21—M&T—1500 Blks.

Held by permission of Dr. Woodall D.O. Mountain

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86632

CERTIFICATE OF DEATH

90 D 86632

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Winfield Himes (Hines)

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country):

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Johns Hopkins Hospital
(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial County Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 26, 1924, to Apr 27, 1924, that I last saw him alive on Apr 27, 1924, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows: Subacute bacterial endocarditis (Strep viridans), Cardiac insufficiency, Hemiplegia left cerebral embolism

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. R. Hannon, M. D.

4/29/24 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health — ADDRESS MAY 3 - 1924

Per [illegible] WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

86633

HEALTH DEPARTMENT—CITY OF BALTIMORE

Varvath

D 86633

CERTIFICATE OF DEATH.

164

1-PLACE OF DEATH

City of BALTIMORE: (No. 344 S. Woodyear St., 19 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Varbatter

(a) Residence No. 344 S. Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Mulatto

5-Single, Married, Widowed, or Divorced, (Write Widow)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Varvath

6-DATE OF BIRTH (month, day and year) DEC 15 1833

7-AGE. 90 yrs. 4 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Martin Schroll

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs. Trobe

(Address) 344 S. Woodyear St.

15- Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr-26, 1924 to May 4, 1924

that I last saw h.er alive on May 4th, 1924

and that death occurred, on the date stated above, at 1.46 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Krug Co., M. D.

, 19 (Address) 130 S. Glover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westen

DATE OF BURIAL. May 6th, 1924

20-UNDERTAKER. John Grubb

ADDRESS 208 N. Fremont

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86634

CERTIFICATE OF DEATH.

109 D 86634

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital, Bulto. Med ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Henrietta J. Wilkins

(a) RESIDENCE NO. 2314 Harlem Ave. — ST. Balto. Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T. Wilkins

6 DATE OF BIRTH (month, day, and year) July 16, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard County Maryland

PARENTS

10 NAME OF FATHER ------ Bewley

11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know

14 Informant Mr. George T. Wilkins

(Address) 2314 Harlem Avenue

15 Filed MAY 5 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 4, 1924,

that I last saw her alive on May 4, 1924,

and that death occurred, on the date stated above, at 9 or A. m.

The CAUSE OF DEATH* was as follows:

Septic Sore throat

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Streptococcus Septicemia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of ——

Was there an autopsy? No.

What test confirmed diagnosis? Physical examination + throat culture.

(Signed) E.W. Sickel M. D.

. 19 (Address) Women's Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 5/6 1924

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-002

D 86635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 Md Ave West part ST. 25 WARD)

2-FULL NAME Edna Marsh Shearer

(a) RESIDENCE No. 309 Maryland Ave West part St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6/12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm H Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Edna [redacted]
(Address) 309 Md ave W P

15 MAY 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sat: May 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1924, to May 3rd, 1924, that I last saw her alive on May 3, 1924 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute interstitial nephritis

(duration) yrs. mos 30 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Bernard Greene, M. D.

5/6, 1924 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westen	May 6 1924
20 UNDERTAKER John J Fields	ADDRESS 1200 W Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86636

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 86636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert and 3 Ford St., 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma June Flensburg

(a) RESIDENCE No. 104 N. Stricker St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Flensburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Rhoda Gaither

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rhoda Flensburg
(Address) 104 N. Stricker St.

15 Filed MAY 5 - 1924 ROBERT R. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17

I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to May 4, 1924,

that I last saw h.. alive on May 4, 1924,

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bilateral otitis media

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 23, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald C Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Monday May 5 24
20 UNDERTAKER	ADDRESS
H. H. Wetzel	Edmondson Ave & Longwood St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86637

CERTIFICATE OF DEATH.

X120 D 86637

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6 ST., WARD)

2-FULL NAME Mrs Mary Caudle.

(a) RESIDENCE No. Bergess Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Wilburn Caudle

6 DATE OF BIRTH (month, day, and year) Nov. 14th. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	39	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Frank M. Major

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wilburn Caudle

(Address) Bengies Md.

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17

I HEREBY CERTIFY, That I attended deceased from May 3rd, 1924, to May 4, 1924.

that I last saw her alive on May 4, 1924

and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH* was as follows:

Acute yellow Atrophy of the Liver

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Toxemia of Pregnancy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory.

(Signed) Captain Cauchiere, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/7/24 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86638

CERTIFICATE OF DEATH.

D 86638

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 E 33rd St. ST., 12 WARD)

2-FULL NAME Harry A Remley

(a) RESIDENCE No. 326 E 33rd.St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. LIFE mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Ella Remley

6 DATE OF BIRTH (month, day, and year) Jan. 2nd. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	64	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Comm. for opening streets

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Remley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Pollard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Edward Remley (Address)

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to May 3, 1924, that I last saw him alive on , 1924, and that death occurred, on the date stated above, at 4:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of parotic gland & glands of neck

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. A. Hartman, M. D.

May 5, 1924 (Address) 2214 Maryfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: 5/6/24 19

20 UNDERTAKER: H. E. Hughes 424 N. Broadway — ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86639

CERTIFICATE OF DEATH. X 129

D 86639

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Anna Brooks

(a) RESIDENCE NO. Baltimore Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Brooks

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3-7			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware Unk

PARENTS

10 NAME OF FATHER Isaac Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Martha Tolbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annie Brooks (Address) Lutherville Md.

Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1924, to May 4, 1924, that I last saw him alive on May 4, 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm M. Edmonds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Taboo A.A. County	5/7/24

20 UNDERTAKER Geo T. A. Gibson ADDRESS 1735 Druid Hill Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86640

CERTIFICATE OF DEATH.

101-60 D 86640

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Parkwood Ave. St. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Miller

(a) RESIDENCE NO. 2 Parkwood Ave. ST. ..... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L Miller

6 DATE OF BIRTH (month, day, and year) Feby 2-

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... house work

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Murphy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Rose Miller

(Address) 2 Parkwood Ave

15 Filed MAY 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to April 3, 1924, that I last saw her alive on April 3, 1924, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: Cobar pneumonia

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt L Green M. D.

5-4. 1924 (Address) 120 Ausgusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 6th 1924
20 UNDERTAKER Cowan & Sons	ADDRESS
per J. T. Cowan	613 Hollins

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8664E

CERTIFICATE OF DEATH.

31 D 8664E

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 N. Hare ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Roppelt

(Residence in Baltimore: No. 130 N. Hare St.; 50 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH ..... May (Month) 30 (Day), 1924 (Year)

7-AGE,	If LESS than 1 day,
50 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Michael Smith

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Material

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William T. Roppelt

(Address) 130 N. Hare St.

15- MAY 5 - 1924 ROBERT N. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... May (Month) 2 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to May 2, 1924, that I saw h[illegible] alive on May 2, 1924 and that death occurred, on the date stated above, at 10.40 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY ..... (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene L. Pepper M. D.

May 2, 1924 (Address) Deutsch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	May 6, 1924
20-UNDERTAKER	ADDRESS
William E. Schaeffer	1816 Monument

Dr Simmes 1025 N Wolfe St
Wolfe 1702

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 West Conway St., 2V Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Charles E. Latta

(a) Residence No... 129 West Conway St., Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced: (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) March 1. 1876

7-AGE: 48 yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Straw Hat Maker

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer: Goodman Mfg Co 886

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER: Robert F Latta

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER: Emma L Higgins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-

(Informant) Emma L Latta

(Address) 129 W Conway St

15-

Filed ..... 19.....

Robert P. Garrison, Registrar.

MAY 5 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 4. 1924

17-I HEREBY CERTIFY, That I attended deceased from April 29, 1924, to May 2, 1924

that I last saw him alive on May 3, 1924

and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Septicaemia

from Infection of Mouth

(Duration) yrs. mos. 8 days

CONTRIBUTORY (Secondary) after operation on by having some teeth drawn

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Septic infection Lakewood

Did an operation precede death? Date of

Was there an autopsy? Causing Death

What test confirmed diagnosis?

(Signed) Thomas J Simmes, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: May 7, 1924

20-UNDERTAKER: Wm Cook

ADDRESS: 302 E Lanvale

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86643

CERTIFICATE OF DEATH.

161-091 D 86643

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Cor. 33 St. and Calvert St., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Marion Davis

(a) RESIDENCE NO. 857 Woodward ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			12 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Maryland
(State or country)

PARENTS

10 NAME OF FATHER Charles Davis

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Matthews

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Elias M. Davis

(Address) 857 Woodward St

MAY 5 1924 Filed ....., 19 Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 5, 1924, that I last saw him alive on May 5, 1924, and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....

.....

.....

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) ~~Arthur Holly~~ Ray Martin, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/6 1924
20 UNDERTAKER Wm Cook	ADDRESS 702 E North

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86644

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2248 E. North Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hudson

(a) Residence No. 2248 E North Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 14. 1898

7-AGE. 25 yrs. 8 mos. 18 ds.

If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Robert Hudson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Annie Starr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Mrs Annie Hudson

(Address) 2248 E North Ave

15- Filed MAY 5 - 1924 19 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 2 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 2, 1924, to May 2, 1924, that I last saw him alive on May 2, 1924, and that death occurred, on the date stated above, at 8.00 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Hebetudinous & Dyspnea,

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Rickets with very much deformity (Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? N.A. Date of

Was there an autopsy? N.A.

What test confirmed diagnosis? Clinical

(Signed) P. D. Camus, M. D.

5-5, 1924 (Address) 102 E Centre St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL, May 6, 1924

20-UNDERTAKER. Elmer W. Cockey — ADDRESS 924 E Eager

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86645

CERTIFICATE OF DEATH.

101 D 86645

1-PLACE OF DEATH South Balto Gen'l Hosp.

REGISTERED NO.

CITY OF BALTIMORE: No. 1213 S. Light St. ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. O McRae

(a) RESIDENCE No. 1301 N Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Mahon

6 DATE OF BIRTH (month, day, and year) Sept 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Race Track

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William B McRae

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Annie Sigmund

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Parker McRae (Address) 2905 Dr E Eden Ave

15 MAY 5 - 1924 ..., 19 Robt P. Harrison, Registrar

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1924, to 5/5, 1924

that I last saw him alive on 5/5, 1924

and that death occurred, on the date stated above, at 5:20 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 3 wks ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P A Rohrbaugh, M. D.

, 19 (Address) 1629 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 7 1924
20 UNDERTAKER	ADDRESS
Henry W. Miles & Son	805 N Calvert St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86646

CERTIFICATE OF DEATH.

100-00 D 86646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Calhoun ST.; 19 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Chickering.

(Residence in Baltimore: No. 523 N. Calhoun St.; Yrs. ... mos. ... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Nov. (Month) 1 (Day), 1852 (Year)

7-AGE.	If LESS than 1 day,
71 yrs. 6 mos. 4 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School teacher.
(b) General nature of industry, business, or establishment in which employed (or employer): 68

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, E. C. Chickering

11-BIRTHPLACE OF FATHER (State or Country), New Hampshire

12-MAIDEN NAME OF MOTHER Sarah Warfield

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. A. Chickering

(Address) 3604 Clifton Ave.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

MAY 5 -1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 4 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924, to May 4 1924, that I saw her alive on May 4 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

.....

Pleurisy & Bronchopneumonia

(Duration) ....yrs. ....mos. 4 ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) W. Bowman Hood M. D.

May 5, 1924 (Address) 626 N. Gilmor St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	May 6, 1924
20-UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86647

D 86647

31

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 852 Mckim ST., 10 WARD)

2-FULL NAME George M Day

(a) RESIDENCE NO. 852 Mckim ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Day

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dent Inman

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Edgefield Tenn

12 MAIDEN NAME OF MOTHER Edgefield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mary Day

(Address) 852 McKim St

15 MAY 5 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to May 2, 1924, that I last saw him alive on May 2, 1924, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 2 mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Health Department

(Signed) Dr G W Kressman M. D.

5-3. 1924 (Address) 708 Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Cemetery — DATE OF BURIAL May 6 1924

20 UNDERTAKER J Mack McElroy — ADDRESS 1225 Eutaw

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 86648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86648

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 4211 Reisterstown Rd St. 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Di Stefano

(a) Residence No. 4211 Reisterstown Rd St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, WIFE of (HUSBAND of) Luigi Di Stefano

6-DATE OF BIRTH (month, day and year) — 1860

7-AGE. 64 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER, De Paula Calagero

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Concetta Fulco

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14- (Informant) Luigi De Stefano

(Address) 4211 Reisterstown Road

15- Filed MAY 5 - 1924, 192.....

Robert P. Harrison, Registrar.

Asst. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-4-24

17- I HEREBY CERTIFY, That I attended deceased from 4-28- 1924, to 5-4- 1924, that I last saw h.. alive on 5-4 1924, and that death occurred, on the date stated above, at 10.35 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Emphysema

Pulmonary Asthenia

Bronchial pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

Respiratory failure (Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical —

(Signed) S. Di Franco M. D.

5-5, 1924 (Address) 1604 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Vincent Cemetery — DATE OF BURIAL. May 6, 1924

20-UNDERTAKER. Geo J Rutlo — ADDRESS 1735 Hanford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86649

CERTIFICATE OF DEATH.

114 D 86649

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N. Mount St., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Queen

(a) RESIDENCE NO. 505 N. Mount St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) 670
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Queen

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Isiah Queen
(Address) 505 N. Monroe

15 Filed MAY 5 - 1924 192 Robert R. Bartlett, Registrar

Burial Permit clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to Less death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ac. Pleurisy of Left

(duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 5, 1924 (Address) 280 Courtland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL May 6th 1924

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86650

1884 D 86650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Bay View Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Barnes.

(a) RESIDENCE No. 557 Orchid ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Henry Swan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14
Informant Miss Barnes
(Address) 557 Orchard St

15
Filed MAY 5 - 1924 192
Registrar
Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest.
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above. auto Acc.

The CAUSE OF DEATH* was as follows:
Fracture Leg Left.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchio Pneumonia
(duration) 2 yrs. 2 mos. 7 ds.
(Signed) G. S. C. Bladen, M. D.
(Coroner)
May 1 192 (Address) 453 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL May 6 192

20 UNDERTAKER John H. Soader — ADDRESS 1472 Hanover St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS may be properly classified. Exact statements of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86651

CERTIFICATE OF DEATH.

25 101-00

D 86651

1-PLACE OF DEATH

City of BALTIMORE: (No. 332 Maryland Avenue St., Westport Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Wiegand

(a) Residence No. 332 Maryland Avenue, Westport St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Wiegand

6-DATE OF BIRTH (month, day and year) Feb. 16, 1870

7-AGE. 54 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teamster 923

(b) General nature of industry, business, or establishment in which employed (or employer) American Railway Express

(c) Name of employer

9-BIRTHPLACE (city or town) Saxony (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Herman Wiegand

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Wilhelmina Friebaugh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-Informant Herman Wiegand

(Address) 332 Maryland Ave.

15-Date MAY 5 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 28, 1924 to May 3, 1924 that I last saw him alive on May 3, 1924 and that death occurred, on the date stated above, at 7.15 P.M.

The CAUSE OF DEATH* was as follows:

Cold

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lampesis M. D.

5-5-1924 (Address) 826 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	May 7" 1924
20-UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Balto St

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86652

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Sisson St. WARD 17)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Ann Steitzell

(a) RESIDENCE. NO. 2410 Sisson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William H. Steitzell

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	2	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Peter Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs. H. Steitzell

(Address) 2410 Sisson St.

May 5 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922, to May 5, 1924, that I last saw h-r alive on May 5, 1924 and that death occurred, on the date stated above, at 1.25 a m.

The CAUSE OF DEATH* was as follows:

E D

Exhaustion

(duration) yrs. mos. few days ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Latrobe Dorsey M. D.

(Address) 1126 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem. Hampden	5/7. 1924
20 UNDERTAKER Walter Davis	ADDRESS 3307 Paine St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86653

D 86653

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

2-FULL NAME John Keegan

(a) RESIDENCE NO. 443 Pinkney Place WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ Bernice Conniff.

6 DATE OF BIRTH (month, day, and year) 4 | 13 | 1893

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
30 —		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Repairman

(b) General nature of industry, business, or establishment in which employed (or employer) Car Barn. York Road.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER T. Keegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Curtin.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland,

14 Informant Mrs. Bernice Keegan (Address) 443 Pinkney Ave

15 MAY 5 - 1924 Robert P. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1924.

17

I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1924. to May 3, 1924.

that I last saw him alive on May 3, 1924

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Acute Pulmonary Tuberculosis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings.

(Signed) B. M. Rhoads, M. D.

, 19 (Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys - Towson	5/7/24 19
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86654

CERTIFICATE OF DEATH.

90 D 86654

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 Geny ST. 17 WARD)

2-FULL NAME Henrietta Ryan

(a) RESIDENCE NO. 614 George St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert T. Ryan.

6 DATE OF BIRTH (month, day, and year) May 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76 yrs.		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 03
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Albert T. Ryan
(Address) 614 Geny St.

15 Filed MAY 6 1924 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 5, 1924 (Address) 230 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery.	5/6/24
20 UNDERTAKER	ADDRESS
Helen A. Holland	1631 Druid Hill ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

199 D 86655

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Epps

(a) RESIDENCE NO 619 W Lee st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER John Epps (Epps)

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Smith Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mary Smith
(Address) 619 W Lee St.

15 Filed MAY 6 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burnes on Body 2nd

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

(Signed) H K Jones M. D.
(Coroner)

5-6 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
R. I. Parker	May 6 1924
20 UNDERTAKER	ADDRESS
M Allen	5/6/24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86656

1-PLACE OF DEATH

City of BALTIMORE: (No. 1228 E. North ave St., 9th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Henry R Smith

(a) Residence No.... 1228 E. North Ave St., 9th Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred— 9½ yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 7 - 1884

7-AGE. 39 yrs. 9 mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laundry 941

(b) General nature of industry, business, or establishment in which employed (or employer)..... Man

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Christian Smith

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Margt. Connelly

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14- (Informant) Annie M. Smith

(Address) 1228 E. North Ave

15- Filed MAY 6 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

530 E. North Ave

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3, 1924

I HEREBY CERTIFY, That I attended deceased from April 28th, 1924, to May 3rd, 1924

that I last saw him alive on.... May 3rd, 1924,

and that death occurred, on the date stated above, at. 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis.

Approximately (Duration) 1 yr. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy: Bronchitis

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Howard Stansbury M. D.

5/4/, 1924 (Address) 530 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral — DATE OF BURIAL. May 7 1924

20-UNDERTAKER. J. C. Rudefeld — ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86657

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-0011

D 86657

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 523 aisquith street St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Josh~~ Josua Ruben

(a) Residence No. 823 Aisquith street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Lena Ruben

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 74 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

(c) Name of employer..... Cleaning & Dressing

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Balto St

15- Filed MAY 6 - 1924 ROBERT R. KRAUTH, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 5 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2 1924 to May 4 1924

that I last saw h.. alive on May 4 1924

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

4

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hornsellem M. D

5/5 1924 (Address) 733 aisquith st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wilkens Friendship Cem DATE OF BURIAL. 5/6 1924

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Henry S. Buschmann

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86658

CERTIFICATE OF DEATH.

44 D 86658

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 746 W Lexington St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... H. D. Buschmann

(a) Residence No. 746 W Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of the late Lina Buschman

6-DATE OF BIRTH (month, day and year) Sept 7 1847

7-AGE, 8 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... Old Age

(c) Name of employer..... Home

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Dietrich Buschman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Kroger

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany.

14- (Informant) Rev C. Merkel

(Address) 746 W Lexington St

15- 192 ROBERT H. KRAUTER, Registrar.

MAY 6 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 5th 24

17- I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to May 5, 1924, that I last saw h[illegible] alive on May 1, 1924 and that death occurred, on the date stated above at 3 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma Liver

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Leon Hemmeter M. D.

May 5, 1924 (Address) 3002 Garrison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul Protestant Ebay DATE OF BURIAL, May 7, 1924

20-UNDERTAKER, H. Heemann ADDRESS 324 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

86659

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 86659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1362 h Calhoun St.: 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Hack

(a) RESIDENCE. No. 1362 h Calhoun St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Hack.

6 DATE OF BIRTH (month, day, and year) Nov 15, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster 023

(b) General nature of industry, business, or establishment in which employed (or employer) Hauling general Mdse

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Tessone

(Address) 1362 h Calhoun

MAY 6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 — 1924

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1924, to May 4, 1924, that I last saw h— alive on May 4 — 1924, and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Insufficiency

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Macallum & Gary, M. D.

, 19 (Address) 1728 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 6 1924
20 UNDERTAKER Jesse Redden	ADDRESS 436 W. Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86660 HEALTH DEPARTMENT—CITY OF BALTIMORE, MD D 86660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Jeffries.

(a) RESIDENCE NO. 720 Lanvale ST. [redacted] WARD Phila

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9 months		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work GRD

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Albert Jeffries

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Ethel Smith

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hospital Records (Address)

15 Filed [illegible] 19 ROBERT R. KRAUTER, Burial Permit Clerk

MAY 9 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/24

17 I HEREBY CERTIFY, That I attended deceased from 3/1/24, 19..., to 5/5/24, that I last saw him alive on 5/5/24 and that death occurred, on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Fisher, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL May 6 1924

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1720 Ashland Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8666I

CERTIFICATE OF DEATH.

74001 ✓

74 D 8666I

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 Gorman Ave. ST., 20 WARD)

2-FULL NAME Louise Janorske

(a) RESIDENCE NO. 41 Gorman Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 29 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Stegin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Janorske
(Address) 512 N. Payson St.

15 Filed MAY 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry), thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to L.A. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) At once yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton, (Coroner.) M. D.

May 5 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 7, 1924
20 UNDERTAKER Wm. Cook	ADDRESS 502 E. Lanvale St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NO. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86662

CERTIFICATE OF DEATH.

129 D 86662

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2850 Clifton Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie W Lee

(a) Residence No. 2850 Clifton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William P.

6-DATE OF BIRTH (month, day and year) Aug 23/860

7-AGE. 64 yrs. 8 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Fa.

PARENTS.

10-NAME OF FATHER, E. K. Wordward

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Fa

12-MAIDEN NAME OF MOTHER, Stephanie Schofield

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Fa

11- (Informant) William P. Lee

(Address) 2850 Clifton Ave

15-

Filed 192

Registrar.

MAY 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1923 to May 4, 1924

that I last saw her alive on May 3, 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis — High Blood Pressure

(Duration) yrs. 10+ mos. ds.

CONTRIBUTORY (Secondary) Chronic Gast. Nephritis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings — Urine test

(Signed) D. D. Dyer M. D.

May 5, 1924 (Address) 503 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Richmond Va	May 7, 1924
20-UNDERTAKER.	ADDRESS
Wm Cook	502 E. Fort Ave

Spec.—1-10-21—M&T—1500 Bks.

D 86663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 86663

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 N. Caroline ST., 9 WARD)

2-FULL NAME Arthur M. Redman

(a) RESIDENCE No. 1536 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sadie A. Redman

6 DATE OF BIRTH (month, day, and year): Aug 8 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operator Paint Factory

(b) General nature of industry, business, or establishment in which employed (or employer): Wm Brad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Harry C. Redman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hattie Gorsell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Sadie A. Redman

(Address) 1536 N. Caroline

15 Filed MAY 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1924

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1924, to May 4, 1924,

that I last saw him alive on May 4, 1924,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John W. Davidson, M. D.

, 19 (Address) 1714 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	May 7 1924
20 UNDERTAKER: Gurkler-Pinkler	ADDRESS: Eager 739

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

D 86664 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86664

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 861 Woodward ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hubert LeRoy Ebler

(a) RESIDENCE NO. 861 Woodward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 25 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) School boy

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Ernest H. Ebler

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Mary M Bartholow

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Ernest H Ebler

(Address) 861 Woodward St

MAY 6 - 1924 ROBERT R. KRAUTER, Registrar

(Filed) Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1924, to May 4, 1924, that I last saw h alive on 11 3 1924, and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Influenzal)

Acute Pericarditis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Costolow, M. D.

Jo. 1924 (Address) 24 N. Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 6 1924

20 UNDERTAKER James Dignan & Son

ADDRESS 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86665

65-001 ✓ D 86665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion Richardson

(a) RESIDENCE NO. St. George Ave Wilson PARK WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fife yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Dec 19/1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Richardson

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie James

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Henry Richardson
(Address) Wilson Park

15 Filed MAY 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Leukemia

(Autopsy at Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. H. Cullen, M. D.
(Coroner.)

Mat 6/24 192 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cloverly Cemetery	May 7 1924
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	172 Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86666

CERTIFICATE OF DEATH.

31

D 86666

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 E. Madison ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Moore

(a) RESIDENCE NO. 918 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 22/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work XXXX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles E. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Moore
(Address) 918 E. Madison St.

15 Filed MAY 6 - 1924 192

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Pollen, M. D.
(Coroner.)

May 6/24 192 (Address) 508 E. orth Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 6 1924
20 UNDERTAKER Mrs. P. G. Elliott	ADDRESS 1725 Lakeland Ave

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86667

CERTIFICATE OF DEATH.

+45 D 86667

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard - Greene ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E Markstone

(a) RESIDENCE NO. Federalsburg Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? 56 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Edward Markstone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Martha Eckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Mrs Edwin Markstone

(Address) Federalsburg Md

15 Filed MAY 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 30th, 1924, to May 5th, 1924, that I last saw him alive on May 5th, 1924, and that death occurred, on the date stated above, at 7. 15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Colon

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of May. 2. 1924

Was there an autopsy? no

What test confirmed diagnosis? Surgical findings

(Signed) Johnston Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkton Md — DATE OF BURIAL 5/6/24

20 UNDERTAKER W J Dickman & Sons — ADDRESS P.o North Ave

Spec.—8-24-14—M. & T.—2000 Bks.

D. 86668 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 86668

CERTIFICATE OF DEATH. X34

1-PLACE OF DEATH Children's Hospital School REGISTERED NO. C .....

CITY OF BALTIMORE: (No. Green Spring Ave. and 41st St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Robie

(~~Residence in Baltimore:~~ No. Billingsley, Md. RFD St.; ..... yrs., 2 mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) 1921 (Year)

7-AGE. 3 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. M. Thomas Jr.

(Address) Children's Hospital School

15- Robert P. Harrison,

Filed ....., 191.... Registrar.

MAY 6 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6 (Month) (Day), 1924. (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 29 1924, to May 6 1924, that I saw him alive on May 5 1924, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess

Bronchopneumonia

..... (Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary) Tuberculosis - 8th 9th 10th Dorsal Vertebrae (Duration) .....yrs. 20 mos. .....ds.

(Signed) Dr. E. Bennett M. D.

May 6, 1924. (Address) 4 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 2 mos. 7 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Billingsley, Md.

19-PLACE OF BURIAL OR REMOVAL. Waldorf Md

DATE OF BURIAL. 5/6/24

20-UNDERTAKER Angelo Farley

ADDRESS Fredtown Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86669

1-PLACE OF DEATH

REGISTERED NO. 129

CITY OF BALTIMORE: (No. 2300 Ruskin Ave. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abraham Berkowitz

(a) RESIDENCE. No. 2300 Ruskin Ave St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Berkowitz

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Banis Berkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Annie Szpanerski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levin

(Address) 1734 E Balto St

MAY 6 - 1924

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924.

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1924, to May 6, 1924, that I last saw h[illegible] alive on May 5, 1924, and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows:

(1) Chronic Interstitial Nephritis,
(2) Arterio Sclerosis.
(3) hypertrophy of heart.

(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) 0 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination.

(Signed) Chas. S. Neistadt. M. D.

. 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
~~Joh~~ Fair Rosedale	May 6 1924
20 UNDERTAKER	ADDRESS
Jack Levin	1734 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86670 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

205-002 ✓ 205 D 86670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSP. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Burnett

(a) RESIDENCE No. 1726 Swallwood St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	-	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Burnett

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Kate Gerwig

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant
(Address) JOHNS HOPKINS HOSPITAL.

MAY 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1924, to May 5, 1924.

that I last saw her alive on May 5, 1924,

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Secondary Anemia (Food)

(duration) yrs. mos. 2 days

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B

(Signed) Chas R Bunn M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bold Rudesill

DATE OF BURIAL 5/8/24

20 UNDERTAKER W M Cook

ADDRESS 502 E Nan St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86671

CERTIFICATE OF DEATH.

3/ D 86671

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2635 Grunmount Ave St., 9 WARD)

2-FULL NAME Edgar C Chenoweth

(a) RESIDENCE No. 2635 Grunmount Ave St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Chenoweth

6 DATE OF BIRTH (month, day, and year) July 25, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	32	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William J Chenoweth

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Caskey

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Wm J Chenoweth
(Address) 2636 Grunmount Ave

MAY 5 1924

Filed ....., 192 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coll. of T B

Duration 2 yrs. 2 mos. 24 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Chenoweth Jr, M. D.
(Coroner)
192 (Address) 148 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL May 7 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 86672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gardner Marbury

(a) RESIDENCE NO. 11-E-Chase St ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? 62 yrs. 5 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Marbury

6 DATE OF BIRTH (month, day, and year) Dec-2-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	62	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Boiron F. Gardner

11 BIRTHPLACE OF FATHER (city or town) Phila. (State or country) Penna.

12 MAIDEN NAME OF MOTHER Eliza Rogers

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Mrs Albert Marbury-Husband (Address) 11-E-Chase St

15 Filed ..... Registrar

MAY 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 5, 1924.

that I last saw her alive on May 5, 1924

and that death occurred, on the date stated above, at 11.15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis with myocardial insufficiency

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia with Convulsions

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Raymond F Johnston, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery DATE OF BURIAL May 7 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

(G. W. Davis)

D 86673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1408 Cookson St., 24 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Davis

(a) Residence No. 1408 Cookson St., Ward. Lodge Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 25 1906

7-AGE. 17 yrs. 4 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Boork
(c) Name of employer Boork

9-BIRTHPLACE (city or town) Richmond Co (State or Country), Va

PARENTS.

10-NAME OF FATHER, Floyd Davis

11-BIRTHPLACE OF FATHER (city or town) Richmond Co (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Suphonia Clark

13-BIRTHPLACE OF MOTHER (city or town) Richmond Co (State or Country), Va.

14-
(Informant) Suphonia Clark
(Address) Richmond Co Va

15-
Filed MAY 5 - 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1924 to May 6, 1924 that I last saw h.. alive on May 5, 1924, and that death occurred, on the date stated above, at 6:15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Stevens M. D.

5/6, 1924 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, May 8, 1924
Lodge Va.	
20-UNDERTAKER, Thos L. Stevens	ADDRESS 1501 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86674

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 S Patterson Park ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted] Krimmelbein

(a) RESIDENCE NO. 637 S Patterson Park ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 5/5/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 5 min.
			Infant	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Ferdinand Krimmelbein

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Viola Carlisle

13 BIRTHPLACE OF MOTHER (city or town) Hartford (State or country) Conn

14 Informant Ferdinand Krimmelbein

(Address) 637 S. Patterson Park ave.

15 Filed MAY 6 1924, 19

Robert P. Harrison, Registrar

(Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5 1924

17

I HEREBY CERTIFY, That I attended deceased from 7:30 P May 5, 1924 to 7:35 P May 5, 1924.

that I last saw her alive on May 5, 1924

and that death occurred, on the date stated above, at 7:35 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

6 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Gross Signs

(Signed) Raymond A Erickson M. D.

, 19 (Address) 332 S Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	9 May 19
20 UNDERTAKER James Dignan & Son	ADDRESS 1000 S Paca St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86675

001 ✓

74 D 86675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 414 N Paca St ST., 17 WARD)

2-FULL NAME Mrs Kirkland or Kirkley

(a) RESIDENCE NO 414 N Paca ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Robt Kirkland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ladd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant R S Kirkland
(Address) 402 N Eutaw St

15 Filed ... 192 Robert P. Harrison, Registrar

MAY 8 - 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

a few hours
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)

5 5 , 192 (Address) 111 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Bur

DATE OF BURIAL May 6 1924

20 UNDERTAKER W M Routson

ADDRESS 2238 N Smith

MAKE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86676

CERTIFICATE OF DEATH.

65-001 D 86676

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Brossard

(a) RESIDENCE NO. 705 S. Exeter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. - 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Brossard

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rosetta Pizzitotti

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 MAY 6 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1924

17

I HEREBY CERTIFY, That I attended deceased from March 7 , 1924, to May 5th , 1924.

that I last saw h. alive on May 5th , 1924,

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Myeloblastic Leukemia

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Cooper Keith, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 8 1924
20 UNDERTAKER	ADDRESS
Martin W. E. Duffy & Son	372

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86677

CERTIFICATE OF DEATH.

101-09 D 86677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 N. Vincent St., 19 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Keys

(a) RESIDENCE NO. 501 N Vincent St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Keys

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Ernest Keys

(Address) 501 N. Vincent St

15 Filed MAY 6 - 1924, 19.... Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5-24

17 I HEREBY CERTIFY, That I attended deceased from 4-29-24, 19...., to 5-5-24, 19....,

that I last saw h.... alive on 5-4-24, 19....

and that death occurred, on the date stated above, at 6a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) .... yrs. .... mos. 7 ds.

CONTRIBUTORY (Secondary) Debility

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19.... (Address) 15-24 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL 5-7-1924

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1611 McCulloh St St., 14 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME... Marie Beaver

(a) Residence No.... 1611 McCulloh St St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1883

7-AGE, 41 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country) Baltimore Md

PARENTS:

10-NAME OF FATHER, James Stevenson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Va

12-MAIDEN NAME OF MOTHER, Julia Jones

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va

14-

(Informant) Daniel Easton

(Address)....916 Pa ave

15-

Filed..... Robert P. Harrison, Registrar.

MAY 6 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-4-24

17- I HEREBY CERTIFY, That I attended deceased from 4-17, 1924, to 5-4, 1924, that I last saw h.e alive on 5-3, 1924, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) yrs. 11 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) W. H. Hawes, M. D.

5/5, 1924 (Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem — DATE OF BURIAL, 5-7-24

20-UNDERTAKER, Daniel Easton — ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—E.B.R.S.—400 Bks.

D 86679

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86679

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 4601 Pimlico Road St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ida Ellen Linker

(a) Residence No. 4601 Pimlico Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Paul W. Linker

6-DATE OF BIRTH (month, day and year) May 28, 1856

7-AGE. 67 yrs. 11 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Frederick, Md.
(State or Country),

PARENTS.

10-NAME OF FATHER. John A. J. Rutter

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country),

12-MAIDEN NAME OF MOTHER. Margaret E. Watkins

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country),

14- (Informant) Paul W. Linker

(Address) 4601 Pimlico Road

15- Filed MAY 6 - 1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 5th 1924

17- I HEREBY CERTIFY, That I attended deceased from April 16th, 1924 to May 5th, 1924 that I last saw h.r alive on May 4th, 1924 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, primary Obscure in Pancreas

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Heart failure

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. H. Burnett, M. D.

May 5th, 1924 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cemetery	May 9, 1924
20-UNDERTAKER. E. Le Roy Stiffler	ADDRESS 125 E. North Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86680

CERTIFICATE OF DEATH.

D 86680

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (also Know as Daniel Shea)

2-FULL NAME Daniel L. O'Shea

(a) RESIDENCE No. 292 Dalsey St. ST., Brooklyn N.Y. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 Weeks yrs. mos. ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Theatrical Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer) Theatrical Business

(c) Name of employer D. W. Griffith. New York.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John O'Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Gallagher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant M. A. P. Workman

(Address) Belvidere Hotel

Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

Via Penn. Railroad Burial Co. Andrew E. O'Shea - Brooklyn, N.Y.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 6, 1924, that I last saw him alive on May 6, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Pancreatitis

Four days (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Toxemia and Shock

3 days (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Infection before admission to hospital

Did an operation precede death? Yes Date of 5/5/24

Was there an autopsy? No. Diagnosis by Clinical and Operative

What was confirmed diagnosis? Clinical and Operative

(Signed) K. W. Gallagher M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery, Brooklyn	5/7 1924
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86681

CERTIFICATE OF DEATH.

D 86681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 Cornhill West ST., 27 WARD)

2-FULL NAME Grace Sales Van Orden

(a) RESIDENCE No. 15 Cornhill Rd ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 49 yrs. ... mos. ... ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard Van Orden

6 DATE OF BIRTH (month, day, and year) April 3-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Washington D C.

PARENTS

10 NAME OF FATHER John B Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Bostus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Howard Van Orden 15 Cornhill Rd.

Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to May 5, 1924,
that I last saw her alive on May 5, 1924,
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P Bell, M. D.

, 19 (Address) Physician - Resident Town Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Charles Pikesville	May 7 1924
20 UNDERTAKER	ADDRESS
A Fahey & Sons.	182 W Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86682

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 86682

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2672 Lebanon ST., 20 WARD)

2-FULL NAME Dorothy M. Maddocks

(a) RESIDENCE NO. 2672 Lebanon ST., 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): daughter

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	1	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Richard Maddocks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Hefner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: R Maddocks
(Address): 2672 Lebanon St

15 Filed ..... 19..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5 1924, to May 6 1924, that I last saw her alive on May 5 1924, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

Contributory

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) W. A. Hall, M. D.

(Address) 4709 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: May 8 1924

20 UNDERTAKER: Martin Kelly & Sons — ADDRESS: 1827 W North

Cor.—1-12-23—M&T—100 Bks.

D 86683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86683

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Bay View Hospital ST., 76 WARD)

2-FULL NAME Angelo Lorenzo

(a) RESIDENCE NO. 3946 E. Lombard ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emittes Lorenzo

6 DATE OF BIRTH (month, day, and year) 11/7 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bartender
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Petina Lorenzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Emittes Lorenzo (Address) 3919 E Lombard St

15 Filed ..... 192 ..... ROBERT R. KRAUTER, Registrar

MAY 7 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide

Gun Shot Wound Instant (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Wades M. D.

(Coroner.)

192 (Address) 143 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL 5 7 1924

20 UNDERTAKER George J Ruth ADDRESS 1738 Harford Ave

Cut on dotted lines, so that if necessary, certificate may be folded. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86684

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Fleet ST., 2 WARD)

2-FULL NAME James John Dean

(a) RESIDENCE No. 2203 Fleet ST., 2 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER James F. Dean

11 BIRTHPLACE OF FATHER (city or town) Philadelphia (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Margaret Dean
(Address) 2203 Fleet St

15 MAY 7 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 6 - 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 6, 1924.

that I last saw him alive on May 6, 1924,

and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

1 Bronchitis (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Rt lung measles (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum Examination

(Signed) H. L. Simmons M. D.

5-6, 1924 (Address) 722 S. Ann

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 5/7 1924

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 427 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86685

CERTIFICATE OF DEATH.

74-00 D 86685

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N. mount ST., 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louisa Williams

(a) RESIDENCE NO. 216 N. mount ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of J.

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) N. C.

PARENTS

10 NAME OF FATHER Jackson Witherspoon

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary Louisa Witherspoon

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) N. C.

14 Informant Louisa Williams

(Address) 216 N. mount.

MAY 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 5 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-16-, 1924, to 5-5-, 1924,

that I last saw her alive on 5-4-, 1924,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) — yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. H. Haggis, M. D.

5-6-1924 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Raleigh N. C. DATE OF BURIAL May 7 1924

20 UNDERTAKER Brown & Ellerbe ADDRESS 114 W. Lexington St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86686

CERTIFICATE OF DEATH.

100-001 D 86686

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Argyle Ave ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dessaline Virginia Jones

(a) RESIDENCE NO. 1620 Argyle Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None JW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (city or town) South Carolina (State or country)

12 MAIDEN NAME OF MOTHER Susan Clark

13 BIRTHPLACE OF MOTHER (city or town) South Carolina (State or country)

14 Informant Charles Jones

(Address) 1620 Argyle Ave.

15 Filed MAY 7 - 1924 ROBERT. R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 5, 1924, that I last saw her alive on May 5, 1924, and that death occurred, on the date stated above, at 9.05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary) (duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Free, M. D.

5/6, 1924 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn, DATE OF BURIAL May 7 1924

20 UNDERTAKER James E. Wright ADDRESS 1647 Pa Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86687

CERTIFICATE OF DEATH.

100-90' D 86687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Renken

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Municipal Hospital (Address)

15 MAY 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-5-1924

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1924 to 5-5, 1924 that I last saw h[illegible] alive on 5-4, 1924 and that death occurred, on the date stated above, at 6 55 [illegible] m.

The CAUSE OF DEATH* was as follows:

Senile Detention

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5- ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Claude G. Bruce, M. D.

5-5, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 5/7 1924

20 UNDERTAKER John Ulrich

ADDRESS 2[illegible] Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86688 D 86688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2 Registered No. 57

City of BALTIMORE: (No. 109 Collington Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna B. Kunolt

(a) Residence No. 109 Collington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John C. W. Kunolt

6-DATE OF BIRTH (month, day and year) June 20, 1856

7-AGE. 67 yrs. 8 mos. 13 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER. Charles Cook

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER. Margaret A. Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Charles Cook

(Address) Devonshire Driver P.K. Heights

MAY 7 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 27, 19 24 to May 3, 19 24

that I last saw her alive on May 3, 19 24

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (Volvulus)

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb R. Peters M. D

May 5, 1924 (Address) 100 S Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery

DATE OF BURIAL. May 7, 1924

20-UNDERTAKER. H. Sander & Sons

ADDRESS 1710 Fleet St

Spec.—8-24-14—M. & T.—2000 Bks.

D 86689

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ridge & Windsor Ave. Ward)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond McSherry Schaffman

(Residence in Baltimore: No. Ridge Ave & Windsor Ave St.; 2 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, March 7, 1922 (Month) (Day) (Year)

7-AGE, 2 yrs. 1 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Raymond Schaffman

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary A Shenkels

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Raymond Schaffman

(Address) Hickeysville Md

15-

Filed ..... 191. ROBERT R. KRAUTER

Registrar.

MAY 7 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 6, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1924, to May 6 1924, that I saw him alive on May 6 1924, and that death occurred, on the date stated above, at 8:15 A.m.

The CAUSE OF DEATH was as follows:

Gastro-Enteritis and Convulsions

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Thos. J. Englehart M. D.

May 8, 1924 (Address) Woodlawn Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet — DATE OF BURIAL, May 8, 1924

20-UNDERTAKER William Cole — ADDRESS 502 E Pratt

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Stine

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86690

CERTIFICATE OF DEATH. ✓92

D 86690

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME John Stine

(a) RESIDENCE No. Rodgers Forge ST., Md 6w WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. Stine

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jarboe

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hosp. records
(Address)

15 MAY 7 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-6, 1924, to 5-6, 1924

that I last saw him alive on 5-6, 1924

and that death occurred, on the date stated above, at 12 15 P.M.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis involving entire small gut, and secondary to a perforating duodenal ulcer

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5, 6-24

Was there an autopsy? Partial.

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Long Green Md.	May 9 1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fayette St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86691

101-09

D 86691

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Smith

(a) RESIDENCE No. 758 W Fulberry St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10 NAME OF FATHER William H Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 - 1924

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1924, to May 6 - , 1924.

that I last saw h~~e~~ alive on May 6 - , 1924,

and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL 5-9 1924

20 UNDERTAKER David Easton

ADDRESS 916 Gay

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D 86692

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST., WARD)

2-FULL NAME Joseph Johnson

(a) RESIDENCE NO. 1921 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	M.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE~~ of Dorthy Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James R Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dorthy A. Johnson (Address) 1921 E Eager st

15 Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

I HEREBY CERTIFY That I attended deceased from Dec 6, 19 23, to May 6, 19 24, that I last saw h alive on May 6, 19 24, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yr. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. W. Quinn M. D.

, 19 (Address) 1921 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	May 8 1924
20 UNDERTAKER Robt J Turner Son	ADDRESS 442 N Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86693 — 31 — D 86693

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 11 S Castle St., (Ward) " (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo A Craerin Geo A. Craerin G.H.

(a) Residence No. 11 S Castle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mamie Craerin

6-DATE OF BIRTH (month, day and year) March 10 1878

7-AGE. "36" 46 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Steam R.R.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Washington D.C.

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14- (Informant) Mrs Louise Corkran (Address) 11 S Castle St

15- Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 5 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2 1924 to May 5 1924

that I last saw him alive on May 4 1924

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo A Craerin M. D.

5/6 1924 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Private Cemetery	May 7 1924
20-UNDERTAKER, Robt F Turner	ADDRESS 1 N Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86694

CERTIFICATE OF DEATH.

D 86694

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1611 Marshall St. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Razack

(a) Residence No. 1611 Marshall st. St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond J. Razack

6-DATE OF BIRTH (month, day and year) June 28 1881

7-AGE.	If LESS than 1 day.
42 yrs. 10 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Codien

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER, Mary H. Baumgarden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md.

14- (Informant) Raymond J. Razack

(Address) 1611 Marshall St.

15- FILED MAY 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 5 1924.

17- I HEREBY CERTIFY, That I attended deceased from April 1 19 24 to May 5 19 24

that I last saw her alive on May 5 19 24

and that death occurred, on the date stated above, at 2.25 P.M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pneumo Coma

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. Hammerbacher M. D.

May 6 19 24 (Address) Lyndhurst Maryland

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Cross A. A. Co.	5/8 19 24

20-UNDERTAKER,	ADDRESS
D. Frew McCully	130 E. Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86695

CERTIFICATE OF DEATH.

5 74 001 D 86695

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 422 N. Caroline St. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Taylor

(a) Residence No. 422 N. Caroline St. St., Ward.....
(Usual place of abode) all her life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John I. Taylor

6-DATE OF BIRTH (month, day and year) April 1853

7-AGE. 69 yrs. 1 mos. ? ds. If LESS than 1 day, — hrs. or. — min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Sam'l Ferguson

11-BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Ellen Howser

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

11-Informant: Mrs. Allwell (sister)
(Address) 422 N. Caroline St.

15-Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6 May '24.

17- I HEREBY CERTIFY, That I attended deceased from 16 March 1924, to 6 May 1924, that I last saw h[er] alive on 6 May 1924, and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis (Valvular Disease.)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical.

(Signed) E. Mayfield Boyle, M. D.

May 7, 1924 (Address) 425 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cem.	5/8 1924
20-UNDERTAKER.	**ADDRESS**
J. Few McCully	130 E Fort.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86696

CERTIFICATE OF DEATH.

D 86696

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 W. Hamburg ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Adelaid Daniels

(Residence in Baltimore: No. 122 W. Hamburg St. St.; — yrs., 2 mos. — ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) ✓

6-DATE OF BIRTH, September (Month) 12 (Day), 1922 (Year)

7-AGE, 1 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Annapolis Md

PARENTS.

10-NAME OF FATHER, Harry L. Daniels

11-BIRTHPLACE OF FATHER (State or Country). Eastport Md.

12-MAIDEN NAME OF MOTHER Lillian Adelaid Evans

13-BIRTHPLACE OF MOTHER (State or Country). Annapolis Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry L. Daniels

(Address) 122 W. Hamburg St

15-

MAY 7 - 1924

(Signed) ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1924, to May 6 1924, that I saw h.. alive on May 6 1924, and that death occurred, on the date stated above, at 12.45 p.m.

The CAUSE OF DEATH* was as follows:

Measles - Bronchio pneumonia

(Duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Complications Myocarditis

(Duration) ... yrs. ... mos. 4 ds.

(Signed) W. C. Beyer M. D.

May 6, 1924 (Address) #541 N. Milton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Annapolis Md

19-PLACE OF BURIAL OR REMOVAL, Annapolis Md

DATE OF BURIAL, May 7, 1924

20-UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Blks.

D 86697 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Turley

(a) RESIDENCE NO. Toranto, Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Marie Turley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill-work

(b) General nature of industry, business, or establishment in which employed (or employer) Steel worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Turley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Polly Bales

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 MAY 7 -1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar, 1924, to May 6, 1924.

that I last saw him alive on May 6, 1924,

and that death occurred, on the date stated above, at 7:00 p m.

The CAUSE OF DEATH* was as follows:

Infection by Flexner Madsell ? ? Bowel

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Toranto, Ohio

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. P. Hamman, M. D.

5/6/24. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Toranto Ohio	5/7/1924
20 UNDERTAKER	ADDRESS
Frank M Sypherd	Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86698

D 86698

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 S. Sixth St., Brooklyn WARD)

2-FULL NAME Earl. E. G. Langford

(a) RESIDENCE NO. 118 S. Sixth ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Same~~

6 DATE OF BIRTH (month, day, and year) April 3 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 131

(b) General nature of industry, business, or establishment in which employed (or employer) Davis Chemical Co

(c) Name of employer Curtis Bay Md

9 BIRTHPLACE (city or town) Butte City

(State or country) Montana

PARENTS

10 NAME OF FATHER John Langford

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Montana

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know

(State or country)

14 Informant (Address) Miss Ella M Langford 118 S Sixth st Brooklyn

15 Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 4, 1924

that I last saw h~~e~~ alive on May 4, 1924

and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

May 6, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL May 8 1924

20 UNDERTAKER John F Denny — ADDRESS 415 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86699

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D 86699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1719 Light. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E Lowman

(a) RESIDENCE NO. 1719 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29/1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Brooklyn Maryland

PARENTS

10 NAME OF FATHER Arthur E Lowman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Maryland

12 MAIDEN NAME OF MOTHER Laura B Acree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co Va

14 Informant Arthur E Lowman

(Address) 1719 Light st

Filed MAY 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 6, 1924

that I last saw her alive on May 6, 1924

and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	May 8 1924
20 UNDERTAKER	ADDRESS
John F Denny	715 Light st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 106-001 ✓

D 86700

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Motherhouse of Notre Dame St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Thomasine Welsh

(a) Residence No. Aisquith St and Ashland Ave St., ... Ward New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 22. 1857

7-AGE.	If LESS than 1 day.
66 yrs. 4 mos. 14 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Teacher 68

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Lockport
(State or Country), N. Y.

PARENTS.

10-NAME OF FATHER, John Welsh

11-BIRTHPLACE OF FATHER (city or town)... Ireland....
(State or Country),

12-MAIDEN NAME OF MOTHER, Sarah McGuern

13-BIRTHPLACE OF MOTHER (city or town).. Ireland....
(State or Country),

14-

(Informant) Sister Mary Dismas

(Address) Notre Dame Aisquith St.

15-

MAY 7 - 1924

ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6 - 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 6, 1924, that I last saw h.. alive on May 5, 1924, and that death occurred, on the date stated above, at 5.45 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia 7

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? St. Andrews Monument Woodlawn Cem

Did an operation precede death? ....Date of.....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. J. Tinker M. D.

5/6, 1924 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Olivet Md	May 8, 1924
20-UNDERTAKER.	**ADDRESS**
Frank A. Tinker	910 E. Gay St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Walley.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86701 — 47 D 3670F

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2136 McCulloh ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Walley

(a) RESIDENCE. No. 2136 McCulloh ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Nelson Walley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Shorter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nelson Walley
(Address) 2136 McCulloh Street

15 MAY 7 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1923, to May 6, 1924, that I last saw h.. alive on May 3, 1924 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of (?)

Was there an autopsy? No

What test confirmed diagnosis? Vision

(Signed) W. H. Pearce, M. D.

, 19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	5/8/24

20 UNDERTAKER	ADDRESS
Geo. T. A. Gibson	1735 Druid Hill Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Michal Muschanowsky.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86702

CERTIFICATE OF DEATH.

74-001 D 86702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Muschanowsky.

(a) RESIDENCE NO. 508 S. Montford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna Muschanowsky.

6 DATE OF BIRTH (month, day, and year) Sept. 10. 1866.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Smelter. 8 6

(b) General nature of industry, business, or establishment in which employed (or employer) Can Factory

(c) Name of employer Southern Can. Co.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Muschanowsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Polald.

12 MAIDEN NAME OF MOTHER Mary Sicholski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant W. F. Sadowski for Anna Muschanowsky.

(Address) 508 S. Montford ave

15 Filed MAY 7 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/30, 1924, to 5/6, 1924, that I last saw h~~im~~ alive on 5/6 1924 and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemmorhage.

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) Arteria sclerosis and hypertension (duration) several yrs. ds.

18 Where was disease contracted if not at place of death? Athens.

Did an operation precede death? ~~was~~ date of..

Was there an autopsy? YES

What test confirmed diagnosis? Sp. Fld. and autopsy.

(Signed) Isidore S. Frey M. D.

May, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL 5/9 1924

20 UNDERTAKER W. F. Sadowski. ADDRESS 705 S. Ann

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-0B 86703

1-PLACE OF DEATH

City of BALTIMORE: (No. 2915 St. Paul St. 17 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Onion

(a) Residence No. 2915 St. Paul St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Ludington

6-DATE OF BIRTH (month, day and year) ----------

7-AGE. 63 yrs. -- mos. -- ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Canner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William F. H. Onion

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Co., Md

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Do not know

14- (Informant) G. Franklin Onion

(Address) 2915 St. Paul St.

MAY 7 - 1924 ROBERT R. KRAUTER,

Filed 192 Registrar.

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., to May 5 1924, that I last saw h. alive on May 5 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral haemorrhage

Sudden (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

(Duration) unknown ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Gerwig M. D.

, 19 (Address) 330 N. Charles st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cemetery	May 7/24, 19....
20-UNDERTAKER.	**ADDRESS**
H. W. Hears & Son	805 Calvert St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86704

D 86704

CERTIFICATE OF DEATH.

91-06

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 S. Third ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gertrude Elbertt

(a) RESIDENCE. NO. 621 S. Third St. ST., 26 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Elbertt

6 DATE OF BIRTH (month, day, and year) Jan. 6-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Adam Rieger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Katherine Neutgelback.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertrude Elbertt (Daughter)

Address) 621 S. Third St.

15 Filed MAY 7 1924, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 3 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1924, to May 3, 1924, that I last saw her alive on May 3, 1924, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Ok Exam

(Signed) Geo Clinton Blades, M. D.

, 19.. Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL May 8th 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 86705

CERTIFICATE OF DEATH

90 D 86705

REGISTERED No. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2630 E Oliver St. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fred Rosenberger

(Residence in Baltimore: No. 2630 E Oliver St. ~~1~~ 50 yrs. ~~10~~ mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word): Married

6-DATE OF BIRTH: June 26, 1859 (Month) (Day) (Year)

7-AGE: 64 yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Germany

PARENTS

10-NAME OF FATHER: Joseph Rosenberger

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (State or country): .....

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. D. Byrne

(Address) Corner Southern

15 MAY 7 - 1924 ROBERT R. KRAUTER, Burial Permit ~~Clerk~~ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May 5 (Month) (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to May 5 1924

that I saw h..... alive on May 5 1924

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis, Valvular disease of heart

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Byrne M. D.

May 5, 1924 (Address) Corner Southern

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, If not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: May 9 1924

20-UNDERTAKER: Lilly & Zeiler ADDRESS: 1033 W Fayette

Cor.—1-12-23—M&T—100 Bks.

D 86706

HEALTH DEPARTMENT—CITY OF BALTIMORE

1884 D 86706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST.? No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Lotman

(a) RESIDENCE No. 3418 Myrtle Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Lotman

6 DATE OF BIRTH (month, day, and year) Sept 3 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER George H. Lotman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Sarah Straka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Elizabeth Lotman
(Address) 3418 Myrtle Place

15 MAY 7 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Cerebral Hemorrhage Fracture of Skull

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

(Signed) Geo Clinton Hodges, M. D. (Coroner)

5/6/24, 192 (Address) 1436 Bona

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 8 1924
20 UNDERTAKER Lilly and Zeih	ADDRESS 403 N. Mon

CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state cause stated EXACTLY. Exact statement of OCCUPATION may be properly classified. See instructions if not entirely clear. Answers to questions 7, 16, 17, 18, 19, 20 are very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86707

CERTIFICATE OF DEATH.

D 86707

15 - 129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3016 Westwood Ave ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Joseph Weber

(a) RESIDENCE. No. 3016 Westwood Ave St.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W. White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie E Weber

6 DATE OF BIRTH (month, day, and year) Feb 23, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Annie E. Weber
(Address) 3016 Westwood Ave

15 Filed 1924 Robert P. Harrison, Registrar

MAY 7 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16th 1924, to May 6th 1924,
that I last saw him alive on May 6th 1924,
and that death occurred, on the date stated above, at 11.10 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Carcinoma Sigmoid Rectum
Nephritis
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Prostate
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Chemical

(Signed) Geo. H. Lamneback, M. D.
5-7, 1924 (Address) 215 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	May 9 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins St

Cor.—1-12-23—M&T—100 Bks.

D 86708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 86708

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Grant ST., 5 WARD)

2-FULL NAME Inv. Osborne

(a) RESIDENCE No. 231 N. Grant ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 23	years			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 067
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant ..... Nice Dr'r
(Address)

15 Filed ....., 192 Robert P. Marrison,
Registrar

MAY 7 - 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Ripley, M. D.
(Coroner)

May 5, 192 (Address) 16 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health, — ADDRESS .....

UNIVERSITY OF MARYLAND.

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be careful to see that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86709

CERTIFICATE OF DEATH. 31

D 86709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Eden ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Williams

(a) RESIDENCE NO. 523 N. Eden ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col'd	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55 years	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

087

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

Burial Permit Clerk

MAY 7 - 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ulcus intracranium

Dont Know (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dudley W. Riley, M. D.
(Colored)

April 3, 192 4 (Address) 1659 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 192

20 UNDERTAKER Commissioner of Health,
Per. Wm. F. Rossell

ADDRESS

FOR THE REGISTRAR

Cor.—1-12-23—M&T—100 Bks.

H.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86710 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86710

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1204 Homewood Ave. WARD 10)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Eugene McKenna

(a) RESIDENCE NO. 1204 Homewood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 609

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James J. McKenna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary A. Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James J. McKenna

(Address) 1204 Homewood Ave.

15 Filed MAY 7 - 1924 Robert P. Harrison Registrar

Burial Permit [redacted] Hawe

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1924

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to May 5th, 1924, that I last saw him alive on May 5th, 1924, and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination & Sputum

(Signed) Benj. D. Harold M. D.

May 7, 1924 (Address) 1216 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	May 8 1924
20 UNDERTAKER H. C. Wiedefeld & Sons	ADDRESS Greenmt Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86711

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86711

CERTIFICATE OF DEATH. X 117

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rebecca Heine

(a) Residence No. Relay Md St., Ward. Relay Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. F. Heine

6-DATE OF BIRTH (month, day and year) D.C. 1882

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. House wife

(b) General nature of industry, business, or establishment in which employed (or employer). Domestic Duties

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. James Montgomery

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Mary Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Jos. F. Heine

(Address) Relay Md

15- Filed MAY 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-6-1924

17- I HEREBY CERTIFY, That I attended deceased from 5-4-1924 19.. to 5-6- 19.24

that I last saw h.. alive on May 6 - 19..

and that death occurred, on the date stated above, at 3.16 P. m.

The CAUSE OF DEATH* was as follows: Peritonitis, General.

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Appendicitis, acute.

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes - Date of May 4 - 1924

Was there an autopsy? No -

What test confirmed diagnosis? Operation -

(Signed) S. Tolchman M. D

. 19 (Address) St. Agnes' Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL. May 9th 1924

20-UNDERTAKER. Scott M. Spear ADDRESS Ellicott City Md.

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 7 1924

Cor.—1-12-28—M&T—100 Bks.

D 86712

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86712

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Teneds

(a) RESIDENCE NO. 1724 E.PrestonSt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) June 11/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	33	10	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of werk Electrician Helper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Edgewood Arsenal

9 BIRTHPLACE (city or town) (State or country) Austria-Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Walter J. Mays
(Address) Edgewood Md.

15 Filed MAY 7 1924. 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poisoning-Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] (Coroner), M. D.

May 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 7 1924
20 UNDERTAKER Richard F. Curley	ADDRESS 1108 Guilford Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86713

CERTIFICATE OF DEATH.

83

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. 28th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Doyle

(a) RESIDENCE NO. Mount Hope Retreat ST., 28 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 5 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (?) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md.

15 MAY 7 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 , 1924 , to May 7th , 1924 , that I last saw her alive on May 6th , 1924 , and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Softening - Post Arteriosclerosis

abt (duration) 0 yrs. 5 mos 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

abt (duration) 0 yrs. 5 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

May 7th. 1924 (Address) Mt Hope Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 9 1924

20 UNDERTAKER W. C. Wadefield — ADDRESS 914 Druid Park

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86714

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 435 N. East Ave 47 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Stoffel

(a) Residence No. 435 N. Edt Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, ~~Widowed~~, or ~~Divorced~~. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (~~or~~) WIFE of: Wm. H. Stoffel

6-DATE OF BIRTH (month, day and year): Sept 5th 1896

7-AGE: 32 yrs. 8 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: George Warneka

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Mary Malone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) William H. Stoffel

(Address) 435 N. East Ave

15- Filed MAY 7 - 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 7 192

17- I HEREBY CERTIFY, That I attended deceased from Jan 26 1924 to May 7 1924.

That I last saw h[illegible] alive on May 6 1924.

And that death occurred, on the date stated above, at 4 15 m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma of Breast

General Carcinosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ethanolism

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Conrad Klaut M. D

May 7, 1924 (Address) 701 N Greenwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 10 1924
20-UNDERTAKER	ADDRESS
Jos Joerdens Son	2178 Pen

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Exact instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86715 D 86715

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 935 S Clinton St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Cotter

(a) Residence No. 935 S Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 9-1878

7-AGE. 45 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shipping clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 809

9-BIRTHPLACE (city or town) (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, John Cotter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Lynch.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Margaret Bonner

(Address) 935 S. Clinton St.

15- Filed MAY 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924 to May 6, 1924

that I last saw h. alive on May 22 1924

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) M. J. McAvoy M. D.

5/6/24 1924 (Address) 829 S. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Sacred Heart Cem — DATE OF BURIAL, May 9th 1924

20-UNDERTAKER Geo M. Funk & Son — ADDRESS 811 N Wolfe

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86716

D 86716

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 408 Notre Dame ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary Frances Sheppard

(a) Residence No... 5105 Whitelford ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 20 1853

7-AGE, 70 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Ind

PARENTS.

10-NAME OF FATHER, Josiah Sheppard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ind.

12-MAIDEN NAME OF MOTHER, Fannie Ruppolt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ind.

14-

(Informant) Laura Sheppard

(Address) 5105 Whitelford ave

15-

Filed MAY 7 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 5 - 1924

17- I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 5, 1924, that I last saw h.. alive on May 5, 1924, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Mitral + Aortic Insufficiency

(Duration) 5 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Aortic Dilatation ? Aneurism

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Notre Dame Lane

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. H. Bishop, M. D.

May 6, 1924 (Address) 501 Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, 5/8/24

20-UNDERTAKER, J. A. Horan ADDRESS 3009 E. Baltimore St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86717

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86717

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4801 York Road St., 27 Ward) 90

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James F. Gillespie

(a) Residence No. 4801 York Road St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	W.	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Julia A Gillespie

6-DATE OF BIRTH (month, day and year) May 5 1872

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Bookkeeper

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER. Thomas Gillespie

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Bridget Riley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Julia A Gillespie

(Address) 4801 York Road

15- Filed MAY 7 1924 Robert F. Garrison Registrar.

Wid Forris Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 5, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 5, 1924, that I last saw him alive on May 5, 1924, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(Duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Interstitial Nephritis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S W Smith M. D.

May 8, 1924 (Address) 520 N Sheridan Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	May 8, 1924
20-UNDERTAKER.	ADDRESS
William Cook Sons & Bartlett	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86718

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86718

CERTIFICATE OF DEATH.

129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 227 N. High St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert E. Firth

(a) Residence No. 227 N. High St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed,~~ or ~~Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Virginia Firth

6-DATE OF BIRTH (month, day and year) June 13/1855

7-AGE, ~~Years~~ 69 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), England

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Unknown

14-(Informant)..... Virginia Firth

(Address)..... 227 N. High St

15-Filed..... 192.. Robert P. Harrison, Registrar.

MAY 7 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 2/24

17-I HEREBY CERTIFY, That I attended deceased from March 10th 19 24, to May 2nd 19 24

that I last saw him alive on May 6 19 24

and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo W Hemmeter M. D.

5/7, 1924 (Address) 3002 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem't | DATE OF BURIAL, May 8....., 19.24

20-UNDERTAKER, William Sack | ADDRESS 502 E. Balto

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86719

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 14 Ward) 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Scott

(a) Residence No. 1529 McCullough St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885

7-AGE.	If LESS than 1 day,
39 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Chauffeur 23

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Savannah, (State or Country), Georgia

PARENTS.

10-NAME OF FATHER, Tony Scott

11-BIRTHPLACE OF FATHER (city or town). Georgia (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). Florida (State or Country),

14-

(Informant). Daniel Eastern

(Address). 916 E. Pratt

15-

Filed MAY 7 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-6-24

17- I HEREBY CERTIFY, That I attended deceased from 5-4, 1924 to 5-6, 1924

that I last saw h~~im~~ alive on 5-6, 1924

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. 9 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + Autopsy

(Signed). Claude S. Bruce M. D.

5-6, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
MT Auburn	5-8, 1924
20-UNDERTAKER.	ADDRESS
Daniel Eastern	916 E Pratt

Burial Permit Work.

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86720

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86720

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 813 W. Saratoga St., 18 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Gibson

(a) Residence No. 813 Saratoga St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, William Roe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Sarah Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Sarah Roe

(Address) 813 W. Saratoga St.

15- Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Given Clerk.

MAY 7

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 5

17- I HEREBY CERTIFY, That I attended deceased from April 24 19 24 to May 5 19 24

that I last saw h.. alive on May 5 19 24

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam.

(Signed) [illegible] M. D.

5/6/1924 (Address) 1076 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn Cem	5-7, 19 24
20-UNDERTAKER,	ADDRESS
Dent Eagburn	916 Pa ave

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-28—M&T—100 Blks.

SMITH

D 86721 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 86721

CERTIFICATE OF DEATH. 167-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037½ Gilmor ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E. Smith

(a) RESIDENCE NO. 1037½ Gilmor ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Royal Laundry

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Lena Bauer
(Address) 3310 Chestnut Ave

15 Filed MAY 7 - 1924 Robert F. Harrison Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by gas inhalation
(Illuminating)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. F. Hennessy, M. D.
(Coroner.)

May 6, 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cemetery	May 8, 1924

20 UNDERTAKER John Cook ADDRESS 502 E. Fayette Ave

...IGN RESERVED FOR BINDING
...NK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY, WITH UNFADING INK—
...GE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be
...at it may be properly classified. Exact statement of OCCUPATION is very important.
... on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86722

CERTIFICATE OF DEATH.

90 D 86722

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Orleans ST., 6 WARD)

2-FULL NAME Louis Brown

(a) RESIDENCE No. 1144 Orleans St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Common

9 BIRTHPLACE (city or town) (State or country) Dallas, Texas

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) 11

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) 11 (State or country)

14 Informant Byron Wright
(Address) 1218 McElderry St

15 Filed MAY 8 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Endocarditis

(Valvular Insufficiency)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Watts, M. D.
(Coroner.)

May 7/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL 5/8/24 192

20 UNDERTAKER Byron Wright — ADDRESS 1218 McElderry

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 ✓ D 86723

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 926 N. Caroline St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Newman

(a) Residence No. 926 N. Caroline St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mrs Anna M. Newman

6-DATE OF BIRTH (month, day and year) Jan. 23 1846

7-AGE. 78 yrs. 3 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired 080

(b) General nature of industry, business, or establishment in which employed (or employer). Clothing Examiner

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS

10-NAME OF FATHER. John Newman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Kn—

11- (Informant) Mrs. Anna M. Newman

(Address) 926 N. Caroline St.

15- MAY 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 6 1924

17- I HEREBY CERTIFY, That I attended deceased from April 25 19 24 to May 5 19 1924

that I last saw him alive on May 5 19.....

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Entered Probate Cystic Kid. 2 ~

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis 5

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Ernest E. Lehnert M. D

(Signed)

May 6 1924 (Address) 926 N. Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	May 9 1924
20-UNDERTAKER.	ADDRESS
Henry Hoeck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86724 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86724

CERTIFICATE OF DEATH.

90 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 805 Vine St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Eugene Turner

(a) Residence No. 805 Vine St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year) May 12 - 1862

7-AGE, 4y yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cutter 12-3

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country).

PARENTS.

10-NAME OF FATHER. Joseph Turner

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country).

12-MAIDEN NAME OF MOTHER, Josephine Brown

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country).

14- (Informant)..... Alfred Tarr Brown

(Address)..... 63 W. Ward St

MAY 8 - 1924 Filed..... 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6 - 24

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24, to May 6, 19 24,

that I last saw h... alive on May 5, 19 24,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Organic Dis. Heart

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. Howard, M. D.

May, 19 24 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn DATE OF BURIAL, May 10, 19 24

20-UNDERTAKER. L. W. Brown & Son ADDRESS 108 W Mondo St

Spec.—6-0-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86725

D 86725

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Strecher St.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Gray

(a) RESIDENCE. No. 607 Strecher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(●) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7 1909

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	14	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Addie Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cora Gray
(Address) 617 Arthur St

15 Filed MAY 8 - 1924 . 19

ROBERT R. KRAUER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15 1924 to May 6 1924

that I last saw her alive on May 3 1924

and that death occurred, on the date stated above, at 2.40 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Genit urine

(Signed) D Hamill M. D.

5/7, 19 (Address) 1400 Mc

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 9 1924
20 UNDERTAKER	ADDRESS
H. W. Brown & Son	1061 W Mon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 86726

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 7 WARD)

2-FULL NAME Charles Buckingham

(a) RESIDENCE No. 730 N. Linwood ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Chas Buckingham

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Municipal Hospital Records (Address)

15 MAY 3 - 1924 16 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1922, to 5-7, 1924 that I last saw him alive on 5-6, 1924 and that death occurred, on the date stated above, at 6 20 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Hypertension
Chronic Nephritis

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub

(Signed) Claude B. Dorsey, M. D.

5-7, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 5/9 1924

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

Cor.—1-12-23—M&T—100 Blks.

D 86727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86727

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

CITY OF BALTIMORE: (No. 1432 Penna. Ave., ST., 14 WARD)

2-FULL NAME Samuel Rubin

(a) RESIDENCE NO. 4011 Barrington Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clara Rubin

6 DATE OF BIRTH (month, day, and year) about 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mfg., Furniture Set
(b) General nature of industry, business, or establishment in which employed (or employer) Parler Frames
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER David Rubin

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Jack Lurvo
(Address) 1439 E. Balto. St.

15 MAY 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis
Hypostasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage.

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 8, 1924 (Address) 2102 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dale Methodist Cem.	May 8 1924
20 UNDERTAKER	ADDRESS
Jack Lurvo	1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 86728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 58 S Carrollton Ave ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E McDevitt

(a) RESIDENCE, NO. 58 S Carrollton Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 31, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machine Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 031

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER Bernard McDevitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Margaret Rond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

Informant Margaret McDevitt
(Address) 58 S Carrollton Ave

MAY 8 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1924, to May 5, 1924, that I last saw him alive on May 5, 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of 4 months ago

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. C. Haines, M. D.

(Address) 3402 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	May 9 19

20 UNDERTAKER John J Fields ADDRESS 1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be required. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Sievers)

D 86729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86729

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 841 W. Franklin St., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Sievers

(a) RESIDENCE NO. 841 W. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Sievers

6 DATE OF BIRTH (month, day, and year) Oct. 26 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): General work

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Wm. Sievers

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant..... (Address).....

15 Filed ..... 19 .....

MAY 8 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1923, to May 5, 1924, that I last saw him alive on May 4, 1924, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Valvular disease heart

Aortic Regurgitation

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Wm. E. Dapur, M. D.

May 7, 1924 (Address) 1005 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL May 8 1924

20 UNDERTAKER: Wm. H. Chase & Son — ADDRESS 1500 Madison

Cor.—1-12-23—M&T—100 Bks.

William W Jones

D 86730

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86730

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Mrs W. Jones

(a) RESIDENCE NO Patapsco Park A.A. Co Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Marr'd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Jones

6 DATE OF BIRTH (month, day, and year) July 5-83

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Jos. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sallie Jones
(Address) Patapsco Park

15 Filed MAY 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or inquiry~~.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or ~~inquiry~~.) find that said deceased came to Ens death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

(duration) ..... yrs. a few hrs. mos. ..... ds.

CONTRIBUTORY (Secondary) Fell from Bridge on R.R. Bridge

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Grinnell, M. D.
(Coroner.)

5-6, 1924 (Address) 111 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 6 1924

20 UNDERTAKER Dan'l F. Case & Son

ADDRESS 400 Mosher

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 86731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86731

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 N. Carey ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Douglass Lee

(Residence in Baltimore: No. 1338 N. Carey St.: 25 yrs., 10 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.)
M	Colored	Single

6-DATE OF BIRTH. July (Month) 17 (Day), 1924 (Year)

7-AGE. 25 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter 070
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. md

PARENTS.

10-NAME OF FATHER, James Lee

11-BIRTHPLACE OF FATHER (State or Country), S. Carolina

12-MAIDEN NAME OF MOTHER Helen Edwards.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Helen Lee

(Address) 1338 N. Carey St.

15-

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

MAY 8 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 6 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 22 1924, to May 6 1924, that I saw him alive on May 5 1924, and that death occurred, on the date stated above, at 2.20 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Chr. Rheumatism Nephritis

(Duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Exhaustation

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) W. T. Stringfellow M. D.

May 6, 1924 (Address) 637 Woshington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn cemtery

DATE OF BURIAL. May 8, 1924

20-UNDERTAKER Mrs Jas. H. Dennis

ADDRESS 1303 Brentman St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17,594 86732

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ D 86732

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Cohen

(a) RESIDENCE NO. 734 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3rd 1922

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
1	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed — 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1924. to May 6, 1924.

that I last saw her alive on May 6, 1924.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Meningetis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute General Miliary Tuberculosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bagg M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL April 8 1924

20 UNDERTAKER R C Gross — ADDRESS 1405 McElderry

Cor.—1-12-23—M&T—100 Bks.

D 86733

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 86733

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1758 Bank ST., W WARD)

2-FULL NAME Joseph . Poproch

(a) RESIDENCE No 1758 Bank ST., WARD 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wiktorya Poproch

6 DATE OF BIRTH (month, day, and year) March 1 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) On Tracks
(c) Name of employer Balto Ohio Rail Road

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mrs. Wiktorya Poproch
(Address) 1758 Bank Street

15 Filed ....., 192 .....

ROBERT R. KRAUTER,
Burial Permit Clerk
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

3 (duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Broken Compound

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos C Sutton Blades, M. D.
(Coroner.)

May 8, 192 (Address) 1438 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary May	9 192 4
20 UNDERTAKER John M Weber	ADDRESS 803 Bank St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86734

D 86734

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 320 S. Durham St., 7 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Martha . Zygmunt

(a) Residence No. 320 S. Durham St., Ward 2

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-if married, widowed, or divorced HUSBAND of (or) WIFE of John Zygmunt

6-DATE OF BIRTH (month, day and year) Nov 1 1890

7-AGE. 33 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER, Martin. Wolski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Maryanna . Lublewski

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

11- (Informant) Mr. John . Zygmunt

(Address) 320. S Durham Street

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

MAY 9 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6 1924

17- I HEREBY CERTIFY, That I attended deceased from April 11 - 1924, to May 6 - 1924

that I last saw h.. alive on " 8 - 1924

and that death occurred, on the date stated above, at 545 P.m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) C. S. Baer M. D

5/7/24 (Address) 408 S Pat Park ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	May 9 1924

20-UNDERTAKER,	ADDRESS
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86735 101-001 ✓ D 86735

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #16 S. Carlton ST., 18 WARD)

2-FULL NAME Mary E. Campbell.

(a) RESIDENCE NO. 16 S. Carlton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John A. Campbell.

6 DATE OF BIRTH (month, day, and year): April 13/1862.

7 AGE — Years: 62. Months: 0 Days: 25 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Daniel P. Campbell.

(Address) 16 S. Carlton St.

MAY 8 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 9, 1924, that I last saw h— alive on May 6, 1924, and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardio Asthenia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward Templeton M. D.

(Address) 24 E. Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden. DATE OF BURIAL: 5/9. 1924

20 UNDERTAKER: J. Hall Davis ADDRESS: 3307 Pine St

at 10 am

Spec—12-23-21—E.S.R.S.—400 Bks.

D 86736

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86736

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2019 Ingwood St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rufus N. Suter

(a) Residence No. 2019 Ingwood St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A.

6-DATE OF BIRTH (month, day and year) Nov. 4 43

7-AGE.	If LESS than 1 day.
80 yrs. 6 mos. 2 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired 813

(b) General nature of industry, business, or establishment in which employed (or employer)..... Butcher

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Martin Suter

11-BIRTHPLACE OF FATHER (city or town)..... Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Boilen

13-BIRTHPLACE OF MOTHER (city or town)..... Pa.
(State or Country),

14-

(Informant) Mary A. Suter

(Address) 2019 Ingwood St.

MAY 8 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-6-24

17- I HEREBY CERTIFY, That I attended deceased from

1-15 1924 to 5-6 1924

that I last saw h[illegible] alive on 5-6 1924

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 6 mos. - ds.

CONTRIBUTORY (Secondary) (Hypertension (Chronic))

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Phys Exam

(Signed) [illegible] M. D.

5/7, 1924 (Address) 1928 [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn	May 8 1924
20-UNDERTAKER.	ADDRESS.
W M Rouston	2238 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86737

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Miller

(a) Residence No. 1213 Poplar Grove St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W Miller

6-DATE OF BIRTH (month, day and year) March 1843

7-AGE. 81 yrs. 2 mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country). England

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (City or town) (State or Country) Not Known

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Not Known

14- (Informant) Thos E Harvey

(Address) 1213 Poplar Grove

15- MAY 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 8 24

17- I HEREBY CERTIFY, That I attended deceased from April 23 1924 to May 8 1924 that I last saw h[e]r alive on May 8 1924 and that death occurred, on the date stated above, at 4 45 AM

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, findings,

(Signed) S. Goldenberg M. D

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL. May 10 1924

20-UNDERTAKER, W M Roulson — ADDRESS 2238 N Monroe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86738

CERTIFICATE OF DEATH.

47 D 86738

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital, Balto, Md. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Bertha Round.

(a) RESIDENCE NO. 1604 N. Monroe ST. Balto. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar wrapper Off

(b) General nature of Industry, business, or establishment in which employed (or employer): Cigar manufacturing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kelm. Lithuania

PARENTS

10 NAME OF FATHER: Hirsh Lapidus Round.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Lithuania.

12 MAIDEN NAME OF MOTHER: Bessie Rose Brodie.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kelm. Lithuania

14 Informant: Mr. Moses Jacob Round (Address): 1604 N. Monroe St (Mother).

15 Filed MAY 8 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1924. to May 8. 1924.

that I last saw her alive on May 8, 1924.

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right lung.
(metastases from carcinoma of right breast)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam. & X-ray.

(Signed) E. W. Sickel, M. D.

5/8, 1924 (Address) Women's Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: 5/8 1924

20 UNDERTAKER: A. L. Linner & Bro

ADDRESS: 1127 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86739

181-003 ✓OK D 86739

HEALTH DEPARTMENT—CITY OF BALTIMORE

H K Gorsuch
Coroner 7th Dist

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore Eye, Ear, Nose & Throat Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 623 N. Wash'n Square WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Wood

(a) RESIDENCE. No. Lott P.O., Middlesex St. Co. Virginia WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Wood

6 DATE OF BIRTH (month, day, and year): Nov. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: William Blackburn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Anna Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: John W. Wood
(Address): Lott P.O. Middlesex Va.

15 Filed MAY 8 - 1924 ROBERT R. KRAUSER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 8, 1924, that I last saw her alive on May 8, 1924, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH was as follows:

Acute Cocaine Poisoning (Accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 5-8-24

Was there an autopsy? No

What test confirmed diagnosis? Respiratory paralysis

(Signed) H. L. Tackett, M. D.

, 19 (Address) 625 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hornady Grove Va.	May. 8th 1924
20 UNDERTAKER: Lilly & Zeiler	ADDRESS: 403 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86740

CERTIFICATE OF DEATH.

118-00

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1241 w. Gross St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Patrick A. Quaid

(a) Residence No.... 1241 w. Gross St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 5th 1869

7-AGE, 55 yrs. 2 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk in store

(b) General nature of industry, business, or establishment in which employed (or employer)..... 609

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, William Quaid

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Mary Hogan

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14-

(Informant) Mrs. M. Carthy

(Address) 2241 w. Gross Ave

15-

Filed MAY 8 - 1924, 19.....

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6 1924

17- I HEREBY CERTIFY, That I attended deceased from May 5, 19 24, to May 6, 19 24, that I last saw h.. alive on May 6, 19 24, and that death occurred, on the date stated above, at 9 30a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage 6 hours

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Stephen A. Evans, M. D.

, 19 (Address) 1211 North Bl...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Peters Cem	May 9, 19 24
20-UNDERTAKER. John F. Cowan & Son, Per F.F. Cowan	ADDRESS 901 Holliday St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86741

CERTIFICATE OF DEATH.

31

D 86741

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1142 Woodyear ST., 16 WARD)

2-FULL NAME Nathaniel Harmon

(a) RESIDENCE NO. 1142 Woodyear Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 23 yrs.				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Celia Robinson
(Address) 1142 Woodyear Ave

15 Filed ..... 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk:

1393

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

May 7, 1924 (Address) 2802 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL

20 UNDERTAKER [illegible] ADDRESS [illegible]

Commissioner Health,

MAY 7 1924

Dep. Wm. H. Wyse

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Murrell)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86742

CERTIFICATE OF DEATH.

161-001 D 86742

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Murrell

(a) RESIDENCE NO. 1504 Gilpper Rd Hampden Md. ST., (City) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4-24

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H. Murrell

11 BIRTHPLACE OF FATHER (city or town) St. Paul
(State or country) Minnesota

12 MAIDEN NAME OF MOTHER Myrtle Dunhart

13 BIRTHPLACE OF MOTHER (city or town) Howard Co.
(State or country) Maryland

14 Informant University Hosp. Baltimore
(Address)

15 Filed MAY 8 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1924, to May 4th, 1924, that I last saw h[illegible] alive on May 4th, 1924, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) David R. Hennemen, M. D.

May, 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL — DATE OF BURIAL MAY 8 1924

20 UNDERTAKER Commissioner Health, — ADDRESS MAY

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86743

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH CITY OF BALTIMORE (No. Homewood Hospital ST., 16 WARD)

2-FULL NAME Frank Gaither Campbell Death Homewood Hospital

(a) RESIDENCE No. 1016 N. Fulton Ave ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: E. Maude Campbell

6 DATE OF BIRTH (month, day, and year): Jan 24 1863

7 AGE: Years 61 | Months 3 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R Office

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Hauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): E. Maude Campbell 1016 N. Fulton Ave

15 MAY 8 - 1924 Robert P. Harrison, 19 Registrar

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to May 5, 1924, that I last saw him alive on May 5, 1924 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At Home or House

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) John H Carey, M. D.

May 5 1924 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 8 1924
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Calvert St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86744 90 D 86744

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1122 Ridgely Street St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Peter James Wolfe

(a) Residence No. 1122 Ridgely Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Wolfe

6-DATE OF BIRTH (month, day and year) Mar. 20, 1859

7-AGE.	If LESS than 1 day.
65 yrs. 1 mos. 17 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... General utility man

(b) General nature of industry, business, or establishment in which employed (or employer)..... B&O Railroad

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Catonsville
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Peter James Wolfe

11-BIRTHPLACE OF FATHER (city or town)..... Catonsville
(State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Short

13-BIRTHPLACE OF MOTHER (city or town)..... United States
(State or Country).

14- (Informant) Mrs. Mary R. Wolfe
(Address) 1122 Wolfe St.

15- Filed MAY 9 1924 Robert P. Harrison, Registrar.

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 11, 1924, to May 7, 1924, that I last saw him alive on May 6, 1924, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis.

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) John L. Sandmann, M. D.

5-7-, 1924 (Address) 1714 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, May 10, 1924
20-UNDERTAKER. Joseph L. B. Cook	ADDRESS 1003 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 86745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D 86745

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22 WARD)

2-FULL NAME Henry Brown

(a) RESIDENCE No. 520 Conway ST., WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Zachariah Brown

11 BIRTHPLACE OF FATHER (city or town) Jamaica (State or country)

12 MAIDEN NAME OF MOTHER Christmia Williams

13 BIRTHPLACE OF MOTHER (city or town) Jamaica (State or country)

14 Informant.....

(Address) UNIVERSITY OF MARYLAND.

15 MAY 8 1924, 19 Robert P. Barnes, Registrar

Burial Forest Glen

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1924

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to May 3, 1924, that I last saw him alive on May 3, 1924, and that death occurred, on the date stated above, at 7:10 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pneumococcus Septicemia

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? C

(Signed) John M. Edmonds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health,

ADDRESS MAY 8 1924

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1590 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 86746

CERTIFICATE OF DEATH.

101 ✓ D 86746

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ryan

(a) RESIDENCE NO. 245 Caldert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 050

(b) General nature of industry, business, or establishment in which employed (or employer) Painter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Stephen Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marie Walsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Archbold Rounds

15 MAY 8 - 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I attended deceased from April 29 1924 to May 5 1924

that I last saw h alive on May 5 1924

and that death occurred, on the date stated above, at 10, 20 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. W. Kelly M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: MAY 8 - 1924

20 UNDERTAKER: Dept Health

ADDRESS

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86747

CERTIFICATE OF DEATH.

3/ D 86747

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Valley View Ave. ST., No WARD)

2-FULL NAME Margaret M. Buckley

(a) RESIDENCE NO. 115 Valley View Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J Buckley

6 DATE OF BIRTH (month, day, and year) June 24, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John W. McClintock

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kirchhamer

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Frank Buckley

(Address) 115 Valley View Ave

15 MAY 8 Filed 1924. 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr 5, 1924, to May 6, 1924, that I last saw her alive on May 5, 1924, and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) Arthur Hurley, M. D.

5/7, 1924 (Address) Mapleton, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 9th 1924
20 UNDERTAKER	ADDRESS
E. D. Fanning & Son - 1938	E. Lafayette Ave.

Burial Permit Clerk

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Maggie Coate)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86748

CERTIFICATE OF DEATH.

3/ D 86748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Sarah ave ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Coats

(a) RESIDENCE No 508 Sarah ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Colr	Marrd

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jun-8-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	3	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Satchel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Gracy Guy.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Grace Mulbrey.
(Address) 1117 W Lexington St

15 Filed ..... 192 Robert P. Harrison Registrar

MAY 8 - 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

..... (duration) yrs. mos. ds.

(Signed) H H Grinnell, M. D.
(Coroner.)

V-8 , 1924 (Address) 1117 W Lexington st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery.

DATE OF BURIAL May 9 1924

20 UNDERTAKER Mrs Jas H. Dennis per T. E. Nelson

ADDRESS 1303 Freestman St.

B.—When [illegible] information [illegible] CAUSE OF DEATH in plain terms [illegible] TION is very important. See instructions on back of [illegible]

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86749

CERTIFICATE OF DEATH.

101-001

D 86749

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2104 Bolton St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Rush Townsend

(a) Residence No. 2104 Bolton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Irving Spence Townsend

6-DATE OF BIRTH (month, day and year) Aug. 8, 1859

7-AGE. 64 yrs. 8 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) Wicomico Co. (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, James Robertson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary E. Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Miss Georgia L. Robertson
(Address) 2104 Bolton Street

15- MAY 9 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 7 1924.

17- I HEREBY CERTIFY, That I attended deceased from April 29 1924 to May 7 1924,
that I last saw her alive on May 7 1924,
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(Duration) yrs. mos. 1h ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) W. F. Love M. D

, 19 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park Cemetery	5/9 19 24
20-UNDERTAKER.	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86750

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 86750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1200 N. Chester St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Schramm

(a) Residence No. 1200 N Chester St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Apr 25 1853

7-AGE	If LESS than 1 day
71 yrs. — mos. 12 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Bernard Schramm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dora Kurr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Chas. Schramm

(Address) 1200 N Chester

12- MAY 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 8, 1924, to May 6, 1924,

that I last saw h. alive on May 6, 1924

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Sign

(Signed) Redeemer E. Hems M. D

May 7, 1924 (Address) 201 N Patterson Pk

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 9 1924
20-UNDERTAKER.	**ADDRESS**
John Ulrich	2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86751 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86751

CERTIFICATE OF DEATH.

155

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Steve Foster

(a) RESIDENCE NO. 129 W. Hofman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Out Town yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butler 070
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Hiram Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah xxxxxxx

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Daniel Easton 916 Penna Ave

15 Filed MAY 9 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Cardiac failure-Post Operativ

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cellulitis of neck-Osteomylitis (duration) yrs. mos. ds.

(Signed) J. E. Mallen, M. D.

May 8/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Victoria. Va.	5-9 1924
20 UNDERTAKER Daniel Easton	ADDRESS 916 Va ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86752

CERTIFICATE OF DEATH.

160 D 86752

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1302 Ruller St. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Cherry.

(a) Residence No. 1302 Ruller St. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 7-1924

7-AGE, ... yrs. 1 mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (City or Town) Balto City (State or Country) Md.

PARENTS.

10-NAME OF FATHER. John Cherry

11-BIRTHPLACE OF FATHER (City or Town)..... (State or Country) N.C.

12-MAIDEN NAME OF MOTHER. Georgia Talbot

13-BIRTHPLACE OF MOTHER (City or Town)..... (State or Country) N.C.

14- (Informant) John Cherry

(Address) 1302 Ruller St

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 7-1924.

17- I HEREBY CERTIFY, That I attended deceased from April 25 1924 to May 7 1924

that I last saw h[illegible]live on May 7 1924

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Duration) 2 yrs. mos. days

CONTRIBUTORY (Secondary) Marasmus

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. A. Krauter M. D.

May 8. 1924 (Address) 112 W. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel Cem. DATE OF BURIAL. 5-9 1924

20-UNDERTAKER. Daniel Easton ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86753

CERTIFICATE OF DEATH.

144 D 86753

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1226 Inorling Ave 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Esther S Larkin

(a) Residence No. 1226 Inorling Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

Married, ~~Widowed, or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Harry S Larkin

6-DATE OF BIRTH (month, day and year) Oct 9 1904

7-AGE. 19 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER Charles E Gordon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Peddicord

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Harry S Larkin

(Address) 1226 Inorling Ave

15- MAY 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 7 1924

17- I HEREBY CERTIFY, That I attended deceased from May 7th, 1924, to May 8, 1924, that I last saw h. alive on May 8, 1924, and that death occurred, on the date stated above, at 11 o A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage Uterus & Post Partum, Shock & Placenta Previa (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of May 7

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) R B Townsend, M. D.

5/8, 1924 (Address) 8547 Cedardale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Forest Lawn DATE OF BURIAL. May 10. 1924

20-UNDERTAKER. CHENOWETH & SON, ADDRESS 2617 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86754

CERTIFICATE OF DEATH.

89 D 86754

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Harford Ave. ST., 10 WARD)

2-FULL NAME Emil F. Pebhardt

(a) RESIDENCE NO. 824 Harford Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Pebhardt

6 DATE OF BIRTH (month, day, and year) Jan. 28 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Samuel Pebhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Josephine Pebhardt
(Address) 824 Harford Ave.

MAY 9 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7. 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1st 1924, to May 6. 1924.

that I last saw him alive on May 6. 1924,

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Insufficiency of Mitral Valve

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? by working

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. F. Pebhardt, M. D.

, 19 (Address) 1001 Edgecombe Cir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Com	May 10 1924
20 UNDERTAKER Frank A. Fink	ADDRESS 915 N. Gay St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86755

CERTIFICATE OF DEATH.

90 D 86755

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3120 Frederick ST., 20 WARD)

2-FULL NAME Charles H. Schnettler

(a) RESIDENCE NO. 3120 Frederick ST., 20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L Schnettler

6 DATE OF BIRTH (month, day, and year) Oct. 14 - 1845

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Schnettler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Vina Goebel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma L Schnettler

(Address) 3120 Frederick Ave

15

MAY 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to May 7, 1924,

that I last saw him alive on May 7, 1924,

and that death occurred, on the date stated above, at 5-50 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Henry J Haber, M. D.

5/8, 1924 (Address) 225 N. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 9, 1924

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Fredk. Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86756

CERTIFICATE OF DEATH.

90 D 86756

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Berman.

(a) RESIDENCE NO. 125 N. Front St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 22 07

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Latzes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Host Roads.
(Address)

15

MAY 9 - 1924

ROBERT R. KRAUTER
Vital Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9 1924

17

I HEREBY CERTIFY, That I attended deceased from 3/10, 1924, to 5/9, 1924.

that I last saw him alive on 5/9, 1924.

and that death occurred, on the date stated above, at 4 40 a.m.

The CAUSE OF DEATH* was as follows:

Bacterial Endocarditis,
(Chronic valvular heart disease)

(duration) 13 yrs. + mos ds.

CONTRIBUTORY (Secondary) Septicemia, Cutaneous Purpura, (duration) over yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? none Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood cultures.

(Signed) Isidor L. Fox, M. D.

May 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 5/9 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86757

CERTIFICATE OF DEATH.

91-502 D 86757

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1533 N Milton Ave ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Gaw

(a) RESIDENCE. No. 1533 N Milton Ave. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mes. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna Maria Gaw

6 DATE OF BIRTH (month, day, and year) Apr 10-1829

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	95	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Gaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hutchinson

14 Informant Mrs. Jennes (Address) 1533 N. Milton

15 Filed MAY 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1924, to May 8, 1924, that I last saw him alive on May 6, 1924, and that death occurred, on the date stated above, at 7.25 P m.

The CAUSE OF DEATH* was as follows:

Old age

Arterio-sclerosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald L Tonry, M. D.

, 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	5/10 1924
20 UNDERTAKER	ADDRESS
J. Fenn McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86758

CERTIFICATE OF DEATH.

74 001

D 86758

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1738 N. Broadway ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Alzina Page

(a) RESIDENCE. No. 1738 N. Broadway ST.. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21-1832

7 AGE 91 Years — Months 14 Days | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Daniel Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. E. Hazard

(Address) 1738 N. Broadway

15 MAY 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to May 7, 1924, that I last saw her alive on May 6- 1924, and that death occurred, on the date stated above, at 8- a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis

(Secondary) Senility (duration) - yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) W. Krauter M. D.

, 19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	5/9 1924
20 UNDERTAKER	ADDRESS
George F. Ruth	1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86759

D 86759

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 26 WARD)

2-FULL NAME Margaret Finnerty

(a) RESIDENCE No. 1527 S. Clinton St ST., 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Michael F. Finnerty

6 DATE OF BIRTH (month, day, and year) March 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) Clinton.Sto.
(State or country) (Canton) Balto.Md

PARENTS

10 NAME OF FATHER Edward Dunnigan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Margaret ------

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Micheal F. Finnerty
(Address) 1527 S. Clinton St

15 Filed MAY 9 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Cerebral Thrombosis or Hemorrhage
(Autopsy at Hebrew Hospital)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. Pericarditis & Pleursy (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. L. Miller, M. D.
(Coroner.)
May 6/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. — DATE OF BURIAL May 9th 1924

20 UNDERTAKER Lilly + Gilen — ADDRESS 4033 Wolfe

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86760

CERTIFICATE OF DEATH.

18 D 86760

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Penna R.R. Pier Easton St.: Easton WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grover C. Graham

(Residence in Baltimore: No. 816 S. Eurley St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Married

6-DATE OF BIRTH, Aug. 6th (Month) (Day), 1884 (Year)

7-AGE,	If LESS than 1 day,
39 yrs. 9 mos. 2 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Penna R.R.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Brakeman

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, George W. Graham

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Mollie Spann

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Graham

(Address) 816 S. Eurley St.

15- MAY 9 - 1924, 191.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 8 (Month) (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiring (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the dny stated above.

The CAUSE OF DEATH* was as follows:

a. Mo.
Worming
(Duration) hours yrs. mos. ds.

CONTRIBUTORY (Secondary) Rickets
(Duration) yrs. mos. ds.

(Signed) Geo. E. Elliott M. D.
(Coroner.)
5/8/24 191... (Address) 1443 E. Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL,
Mount Olivet Cem	May 9, 1924
20-UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86761

CERTIFICATE OF DEATH.

57

D 86761

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ray Pimes Greenberg

(a) RESIDENCE NO. 2810 Rockrose Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Greenberg.

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Pimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Esther ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mr. Joseph Greenberg (Address) Philadelphia, Pa.

15 MAY 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1924, to May 8, 1924, that I last saw h. alive on May 8, 1924, and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Diabetes. Gangrene of left foot
Arteriosclerosis. Auricular fibrillation

(duration) yrs. 2 mos (?) ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor L. Levy, M. D.

May. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 5/9/24 19

20 UNDERTAKER David Sondheim ADDRESS 1118 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86762

100-001

D 86762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Lewis Keach

(a) RESIDENCE NO. Guilford Manor Apts ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? 66 yrs. 7 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)

6 DATE OF BIRTH (month, day, and year) Sept-10-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	66	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) Private School

(c) Name of employer Maryland Kate Mission School

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Cyril N. Keach

11 BIRTHPLACE OF FATHER (city or town) Worcester

(State or country) Mass.

12 MAIDEN NAME OF MOTHER Rachel V. Glaydon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md.

14 Informant Mr. W. K. Magruder

(Address) 909 Calvert Bldg-City

15 MAY 9 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1924, to May 7, 1924, that I last saw h alive on May 7, 1924 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald Chandler M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery — DATE OF BURIAL May 9 1924

20 UNDERTAKER STEWART & MCWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

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THANK

D 86763

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86763

CERTIFICATE OF DEATH.

76

1-PLACE OF DEATH Pine Crest Sanatarium St., 12 Ward) Registered No.....

City of BALTIMORE: (No

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Anna Gove

(a) Residence No. 2412 Maryland Ave St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

gth of residence in city or town where death occurred 63 yrs. 7 mos. 9 ds. How long in U. S. If of foreign birth? 63 yrs. 7 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Fred B. Gove

6-DATE OF BIRTH (month, day and year) Sept-29-1860

7-AGE, 63 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Henry Bien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Meyer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) F. B. Gove - (husband)

(Address) 2412 Maryland Ave

MAY 9 - 1924

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May-8-1924

17- I HEREBY CERTIFY, That I attended deceased from April 9th, 19 24 to May 8th, 19 24, that I last saw h. alive on May 8th, 19 24, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Emmyal S. Cross, M. D.

, 19 (Address) 2409 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19
Pleasant Cemetery	May 10 19 24
20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC
should be carefully supplied. AGE should be stated E
in plain terms, so that it may be properly classified.
Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86764 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 115 Elmwood St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frederick William Wenzel

(a) Residence No. 115 Elmwood St., 27 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., If of foreign birth? 59 yrs. 8 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Otilia A. Wenzel

6-DATE OF BIRTH (month, day and year) Aug-23-1864

7-AGE, 59 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) Groceries

(c) Name of employer Self

9-BIRTHPLACE (city or town) Frederick (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Conrad Wenzel

11-BIRTHPLACE OF FATHER (city or town) unknown (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) unknown (State or Country), Germany

14- (Informant) Mr. Frid'k. C. G. Wenzel (Son)

(Address) 115 Elmwood Ave. City.

15- MAY 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May-8-1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to May 8, 1924, that I last saw h~~im~~ alive on May 8, 1924, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) S. Lee Magness, M. D.

5/8, 1924 (Address) 1206 E. Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, May 10, 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho
in plain terms, so that it may be properly classified. Exact statement of OCCUPA
instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86765

CERTIFICATE OF DEATH.

D 86765

1-PLACE OF DEATH

City of BALTIMORE: (No. 1907 Park Av St. 13 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Neukirch

(a) Residence No. 1907 Park Av St., 13 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? 69 yrs. 2 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of August W. Neukirch

6-DATE OF BIRTH (month, day and year) March-5-1855

7-AGE. 69 yrs. 2 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Chas. Kayser

11-BIRTHPLACE OF FATHER (city or town) (State or Country). unknown Germany

12-MAIDEN NAME OF MOTHER. Mary A. Boschke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). unknown Germany

14- (Informant) Mrs Anna M. Waydner

(Address) 1907 Park Av (daughter)

15-

Filed MAY 9 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May-8-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 2, 1924, to May 8, 1924, that I last saw h[illegible] alive on May 7, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Paralysis of muscles of swallowing and mastication also of face and eyes.

(Duration) about yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 304 Laurens St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Lugrain, M. D.

May 9, 1924 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL. May 10 1924

20-UNDERTAKER. THE STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO... should be carefully supplied. AGE should be stated E... in plain terms, so that it may be properly classified. ... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86766

CERTIFICATE OF DEATH.

46 ✓

D 86766

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Moody

(a) Residence No. 1305 Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

~~Single~~ Married, ~~Widowed, or Divorced~~ (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1872

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ?
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ?
(State or Country),

14- (Informant) Municipal Hospital Records

(Address)

MAY 9 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-5-24

17- I HEREBY CERTIFY, That I attended deceased from 5-3, 1924, to 5-5, 1924, that I last saw h[illegible] alive on 5-5, 1924, and that death occurred, on the date stated above, at 11.55 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(Duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude D. Brace M. D.

5-6, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL, MAY 9 - 1924

20-UNDERTAKER. Commissioner Health

ADDRESS Wm. B. Fowler

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

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100

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86767

CERTIFICATE OF DEATH.

1624

D 86767

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 Rabon ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Groomes

(a) RESIDENCE NO. 638 Rabon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5/6/24

7 AGE — Years — Months — Days: 2

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Groomes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Md

12 MAIDEN NAME OF MOTHER: Lillie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md

14 Informant: Mother.

(Address)

Filed MAY 9 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/8 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 1924 to 5/8, 1924 that I last saw her alive on 5/7, 1924 and that death occurred, on the date stated above, at 11:50 a. m.

The CAUSE OF DEATH* was as follows:

Spontaneous Hemorrhage of Newborn

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Reese, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 9 - 1924

46

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86768

CERTIFICATE OF DEATH.

D 86768

1-PLACE OF DEATH

Registered No. 47

City of BALTIMORE: (No. 519 S Port St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Helena Winks

(a) Residence No.. 519 S. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (~~Write~~ the word.) Widow

5a-If married, widowed, or ~~divorced~~, ~~HUSBAND of~~ (or) WIFE of Samuel Winks

6-DATE OF BIRTH (month, day and year) July 19-1863

7-AGE, 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... None

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... Balto (State or Country)... md

PARENTS.

10-NAME OF FATHER, John Kripp

11-BIRTHPLACE OF FATHER (city or town)... Balto (State or Country)... md.

12-MAIDEN NAME OF MOTHER, Maggie Englide

13-BIRTHPLACE OF MOTHER (city or town)... Germany (State or Country).

14- (Informant)... Thomas Ey

(Address) 519 S Port st

15- Filed ...., 192.. Robert P. Harrison, Registrar.

MAY 9 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 28 1924 to May 7 1924, that I last saw h.r alive on May 7 1924, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

Removed June 1923 (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 1923

Was there an autopsy? no

What test confirmed diagnosis? Lumps

(Signed) D. Smolen, M. D.

, 19 (Address) 301 S Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery — DATE OF BURIAL, May 10, 1924

20-UNDERTAKER, Robt J Turner Jr — ADDRESS 942 N Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86769

CERTIFICATE OF DEATH.

D 86769

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 76 ST., WARD)

2-FULL NAME Ida Forest Wooley

(a) RESIDENCE NO. South Lebanon, Ohio ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Actor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Lebanon Ohio

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) " " (State or country)

12 MAIDEN NAME OF MOTHER Do not "

13 BIRTHPLACE OF MOTHER (city or town) " " (State or country)

14 Informant Geo. B Morris

(Address) 229 West 46th St, N. Y.

15 Filed MAY 9 1924 . 19 Robert F. Griffith, Burial Permit Clerk Registrar

J. BURKE MORGAN, ESCORT VIA. PENN. R.R.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to May 8, 1924, that I last saw him alive on May 8, 1924, and that death occurred, on the date stated above, at 4 45 p m.

The CAUSE OF DEATH* was as follows:

Malegnant Scarlet Fever

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Myron G. Tull, M. D.

. 19 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
South Lebanon Ohio	May 9 1924
20 UNDERTAKER	ADDRESS
Maury W. Measmore	805 N. Calvert St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86770

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-006 86770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2016 Ramsay St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Dietz

(a) Residence No. 2016 Ramsay St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Dietz

6-DATE OF BIRTH (month, day and year) Oct. 17-1854

7-AGE. 69 yrs. 7 mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework done

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Joseph Klarg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Luitgard Lenard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

14- (Informant) Joseph B. Dietz

(Address) 2314 Frederick Ave.

15- MAY 8 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 6. 24

17- I HEREBY CERTIFY, That I attended deceased from May 3 1924 to May 6 1924

that I last saw h alive on May 6 1924

and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Apoplexy)

Arteriosclerosis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert Gutsch M. D

5/9/ 1924. (Address) 215 Dulaney

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loyola Cathedral

DATE OF BURIAL, May 10 1924

20-UNDERTAKER. George L. Schwartz

ADDRESS 4101 Fredk Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86771

CERTIFICATE OF DEATH.

70 D 86771

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emerson D. Davis (W. Arlington)

(a) RESIDENCE No. 3806 Hamilton Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred Davis

6 DATE OF BIRTH (month, day, and year) Nov. 13-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	28	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Albert E. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Sparkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mildred O. Davis

(Address) 3806 Hamilton Ave.

15 MAY 5 - 1924 Robert E. Barnes, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17

I HEREBY CERTIFY, That I attended deceased from 5-5 -, 1924, to 5-8, 1924.

that I last saw him alive on 5-8-, 1924

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Encephalitis -

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 10 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	1121 Eutaw Ave

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 86772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86772

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2. Washington Ave. St.: 27 WARD) REGISTERED No. C .....

2-FULL NAME Thomas Dukehart.

(Residence in Baltimore: No. 2. Washington Ave. St.; yrs., Lifetime mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, Dec. 18—, 1863 (Month) (Day) (Year)

7-AGE, 60 yrs. 4 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Thos M. Dukehart

11-BIRTHPLACE OF FATHER (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Victoria Peirce

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A. Sanford

(Address) 2011 E. Preston St.

15-

Filed MAY 9 1924 Robert F. Harrison Registrar.
Chief Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 5—, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Krusen M. D. (Coroner.)

May 8, 1924 (Address) 3692 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cem. DATE OF BURIAL, 5/9 1924

20-UNDERTAKER Chas. P. Crawford ADDRESS 1180 Nat. Royal Ave.

Spec.—1-10-21—M&T—1500 Blks.

D 86773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 86773

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elsie A Hayden

(a) RESIDENCE NO. 2116 Penrose Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James Hayden

6 DATE OF BIRTH (month, day, and year) June 26, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn, N.Y.

PARENTS

10 NAME OF FATHER Charles Bonnert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn, NY

12 MAIDEN NAME OF MOTHER Katherine Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NY

14 Informant (Address) James D Hayden 2116 Penrose Ave

15 MAY 9 - 1924 19 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 8, 1924

that I last saw her alive on May 8, 1924

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Postpartum Eclampsia - has had pre-eclamptic syndrome for past 2 months

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) A A Sussman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 10 1924
20 UNDERTAKER Wm J Rickuesthaus	ADDRESS North Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86774

D 86774

CERTIFICATE OF DEATH.

REGISTERED NO. 157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Baker ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmond Sheets

(a) RESIDENCE. No. 1623 Baker ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles Sheets

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Charles Sheets, (Address) 1623 Baker St.

15 Filed MAY 9 - 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to May 9, 1924, that I last saw him alive on May 9, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John D. Quinn, M. D.

5/9, 1924 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	5-10 1924

20 UNDERTAKER H. Brauning Son ADDRESS 5 W Schroeder St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lbks.

(John Milton Glauber)

D 86775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104 D 86775

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Mount St. ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Milton Glauber Jr.

(a) RESIDENCE. No. 104 S. Mount St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER J. Milton Glauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Freda Kanne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant J. Milton Glauber.

(Address) 104 S. Mount St.

15 Filed MAY 9 - 1924, 19 Robert L. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1924, to May 7, 1924, that I last saw h[illegible] alive on May 7, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

acute nephritis

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) uraemic convulsions + Coma

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? school probably

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) A. E. Knight, M. D.

May 8, 1924 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 10th 1924

20 UNDERTAKER E. Schlosman & Son ADDRESS 1034 Fairmount Ave

MAY 9 - 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86776

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86776

CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 3662 Falls Road St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... John E. Kailer

(a) Residence No... 3662 Falls Road St., 13 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A. Kailer

6-DATE OF BIRTH (month, day and year) April 29-1849

7-AGE, 75 yrs. — mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Overseer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired 2 years

(c) Name of employer..... Mt. Vernon Woolen Mills

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, James D. Kailer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Mary Mullen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant) Birch G. Kailer

(Address) 3662 Falls Road

15-Filed MAY 9 - 1924, 19?

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 8-1924

17-I HEREBY CERTIFY, That I attended deceased from May, 1922, to May 8, 1924 that I last saw him alive on May 8, 1924 and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis & thrombosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

May 8, 1924 (Address) 3427 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, May 12 1924

20-UNDERTAKER, Horace A. Bruce — ADDRESS 363 Falls Road

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86777

CERTIFICATE OF DEATH.

D 86777

161-801

1-PLACE OF DEATH Helen Hosp, Old 14

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Newton #1

(a) RESIDENCE NO. 2004 Madison Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1924

7 AGE	Years	Months	Days

If LESS than 1 day, 2 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Aaron Newton

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Lerner

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hosp Records
(Address) .....

15 Filed MAY 9 - 1924, 19 .....
Robert P. Morrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to May 8, 1924, that I last saw him alive on May 8, 1924 and that death occurred, on the date stated above, at 7 30 a. m.

The CAUSE OF DEATH* was as follows:

Premature infant - 4 lbs 3/4 oz - One of twins.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Robt G. Wilson, M. D.

, 19 (Address) Helen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Helen Friendship — DATE OF BURIAL March 10 24

20 UNDERTAKER Jack Lewis — ADDRESS 1431 E Balto.

MARGIN RESERVED FOR BINDING

(John G. Grasser)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

86778

101 D 86778

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S Eden ST. 3 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John C Grasser

(a) RESIDENCE. No. 316 S Eden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Grasser

6 DATE OF BIRTH (month, day, and year) Jan 6 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Plumber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Johanna Grasser (Address) 316 S Eden St

15 FILED MAY 9 1924 Robert P. Warfield Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April 29 1924 to May 6 1924, that I last saw h[illegible] alive on May 6 1924, and that death occurred, on the date stated above, at 11:00 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. L. Lee, M. D.

May 7 1924 (Address) 1701 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 10 1924
20 UNDERTAKER	ADDRESS
Geo M Fink & Son	811 N Wolfe St

Burial Permit Given

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86779

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Walnut alley ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. D. Campbell

(a) RESIDENCE NO. 513 Walnut alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 640
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Caroline Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Caroline Campbell
(Address) 513 Walnut alley.

15 Filed MAY 9 1924 Robert P. Harrison Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis about

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. C. Hennessy, (Coroner.) M. D.

May 9, 1924 (Address) 200 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-10 192[illegible]
20 UNDERTAKER Edward Easton	ADDRESS 916 Ba[illegible]

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

1714 43 86780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86780

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 4 WARD)

2-FULL NAME Charles (Bowers) Yost

(a) RESIDENCE NO. 513 W. Mulberry St WARD New York N. Y.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseman

(b) General nature of industry, business, or establishment in which employed (or employer) —"— Ost

(c) Name of employer —"—

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Hellican Bowers

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country) U. S. A

12 MAIDEN NAME OF MOTHER Louise —

13 BIRTHPLACE OF MOTHER (city or town) France
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records

15 Filed MAY 9 - 1924 Robert F. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1924 to May 7, 1924

that I last saw h~~e~~alive on May 7, 1924

and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of urinary bladder

(duration) 1 yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Pyelonephritis

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Eckard, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmell Cemetery	May 10 1924
20 UNDERTAKER Joseph Abrens	ADDRESS 721 Bway

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 10 Street) Belmont (St.,) Ave (Ward)

Registered No. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. David R. Cro

(a) Residence No. 10 ½ Belmont Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 1-1923

7-AGE, 1 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER George H. Cro

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER Helen Butler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) George H. Cro

(Address) 10½ Belmont Ave

15- Filed MAY 9 1924 Robert P. Harrison, Registrar.

Burial Permit Work.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-8-24

17- I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to May 8, 1924, that I last saw him alive on May 8, 1924, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Shock after accidently falling into a tub of water

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) Chas A Feldhoff, M. D.

, 19 (Address) 1807 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL, May 10 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 N North

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86782

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 N Payson ST., 16 WARD)

2-FULL NAME John Grant

(a) RESIDENCE No. 907 N Payson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male COLOR OR RACE White 4 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Grant

6 DATE OF BIRTH (month, day, and year) Mar 6-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Garage 062

(c) Name of employer Frey Hughes & Co.

9 BIRTHPLACE (city or town) London
(State or country) England

PARENTS

10 NAME OF FATHER John Grant

11 BIRTHPLACE OF FATHER (city or town) London
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) London
(State or country) England

14 Informant Mrs Julia Trumpkins
(Address) 907 N Payson St

15 MAY 9 - 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8. 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 1 1924 to May 8 1924

that I last saw h— alive on May 8 1924

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute Uraemia

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Metritis insufficiency

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Bernard L. French M. D.

5/8, 1924 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/10/24

20 UNDERTAKER Geo Leimbach & Son — ADDRESS 647 W Pratt St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86783

CERTIFICATE OF DEATH.

129

D 86783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3502 Hickory Av ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Sandy

(a) RESIDENCE NO. 3502 Hickory Av ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jos. C Dandy

6 DATE OF BIRTH (month, day, and year) Dec 15-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	82	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER William Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nancy Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Gordon Parrish

(Address) 3502 Hickory Ave

15 May 10 1924 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to May 8, 1924, that I last saw h.. alive on May 8, 1924, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) yrs. mos. 2 ds

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ns Date of

Was there an autopsy? ns

What test confirmed diagnosis? Clinical & Chemical

(Signed) C. O. Evans M. D.

May 9, 1924 (Address) 865 N. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL May 10 1924

20 UNDERTAKER C. S. Marshall ADDRESS 3539 Fall Rd

MAY 10 1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86784

91-002 D 86784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3333 Falls Road ST., (13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R. Burrier

(a) RESIDENCE NO. 3333 Falls Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Roberta Burrier

6 DATE OF BIRTH (month, day, and year) Aug 1-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 031

(b) General nature of industry, business, or establishment in which employed (or employer) Machinist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co.

PARENTS

10 NAME OF FATHER Isaac. Burrier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co Md

12 MAIDEN NAME OF MOTHER Eaked & Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Roberta Burrier

(Address) 3333 Falls Road

15 MAY 1 01924 Robert E. Harrison, 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1920, to May 9, 1924.

that I last saw him alive on May 9, 1924,

and that death occurred, on the date stated above, at 11:40 Am.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio - sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

May 9, 1924 (Address) 846 W 36 St - Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL May 12 1924

20 UNDERTAKER A S Marshall ADDRESS 3539 Falls Rd

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86785

D 86785

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 New St. ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Mosley

(a) RESIDENCE NO. 422 New St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing
(c) Name of employer Boulden & S.

9 BIRTHPLACE (city or town) ..... (State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Mabel Mosley
(Address) 1525 Winchester

15 Filed MAY 1 01924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism
(Malaria or Tuberculosis)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner)
May 9, 1924 (Address) 2802 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 5/10 1924

20 UNDERTAKER Mrs Geo H. Dennis per T. E. Kelron

ADDRESS 1303 Presstman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-25—M&T—100 Bks.

D 86786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86786

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 N. Fremont Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha Ramsay.

(a) RESIDENCE NO. 1330 N. Fremont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ransom Ramsay.

6 DATE OF BIRTH (month, day, and year) about 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Means.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Scroggins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Augustus Means
(Address) 1132 N. Calvert St.

15 Filed MAY 1 01924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac. Gastro-enteritis
(Acute Family Cottage Hosp.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart
(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 7, 1924 (Address) 2702 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 5/11 1924

20 UNDERTAKER Mrs Jas H Dennis
per T. E. Kelson

ADDRESS 1303 Freeman St.

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17660 D 86787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1902 159 D 86787

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bell

(a) RESIDENCE NO. 143 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24 - 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
—	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hattie Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 1 01924 Robert P. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1924, to May 1, 1924, that I last saw him alive on May 1, 1924, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows: Congenital Heart Disease

(duration) yrs. 3 mos 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bagg M. D.

19 (Office) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery Md	May 6 1924
20 UNDERTAKER	ADDRESS
Edward Bryan	Orleans St

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86788

CERTIFICATE OF DEATH.

D 86788

100-00

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 235 S. Chapel St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignacy F. Rybarczyk

(a) Residence No. 235 S. Chapel St., Ward. 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 27 1923

7-AGE. ... yrs. 4 mos. 12 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, John. Rybarczyk

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Anna R. Kowalski

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Mr John. Rybarczyk

(Address) 235 S. Chapel Street

15- MAY 10 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9 1924

17- I HEREBY CERTIFY, That I attended deceased from April 30 19 24 to May 9 19 24

that I last saw h. alive on May 8 19 24

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Primary)

(Duration) ... yrs. ... mos. 1 ½ ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Leo Heller M. D.

5/9 19 24 (Address) 1937 South St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	May 10 1924
20-UNDERTAKER,	ADDRESS
John A Weber	1803 Bank St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86789

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2340 N. Calvert St., 12 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Irene Helen Kirkness

(a) Residence No. 2340 N. Calvert St St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 5, 1911

7-AGE. 12 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At home Girl

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore Md
(State or Country).

PARENTS.

10-NAME OF FATHER, Edward J Kirkness

11-BIRTHPLACE OF FATHER (city or town)..... Canada
(State or Country).

12-MAIDEN NAME OF MOTHER, Helen Kolb.

13-BIRTHPLACE OF MOTHER (city or town)..... Balto Md
(State or Country).

14-

(Informant)..... Edward J. Kirkness

(Address)..... 2340 N. Calvert St

15-

Filed MAY 1 01924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 7-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 2, 19 24 to May 7, 19 24,

that I last saw h[illegible] alive on May 7, 19 24,

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

(a) Rheumatic endocarditis

.....(Duration)..... yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute parenchymatous nephritis

.....(Duration)..... yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Urine & Physical exam

(Signed) Geo M Lear M. D.

May 9, 1924 (Address) 1203 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Pk — DATE OF BURIAL, May 10, 1924

20-UNDERTAKER. Louis Neumann — ADDRESS 225 S Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86790

CERTIFICATE OF DEATH.

D 86790

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 12 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Gudson

(a) RESIDENCE. No. 2208 W. Charles St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): December, 1857

7 AGE — Years: 67 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Mrs Mason

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: William Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Rachel Talcher May 8

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Esther Simmons

(Address): Pentagon Apartments

15 Filed ..... 19..... Robert F. Harrison, Registrar

MAY 10 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 22. 1924 to May 7. 1924

that I last saw h.. alive on May 7 1924

and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Haemorrplegia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary): Acute Parenchymatous Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2208 W. Charles St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S T B Hughes M. D.

(Address) 1413 S. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: May 12 1924

20 UNDERTAKER: Samuel Hawkins — ADDRESS: 1128 Bedford

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86791

CERTIFICATE OF DEATH.

185 D 86791

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Joyner

(a) RESIDENCE NO 1701 Homberd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) City
(c) Name of employer

9 BIRTHPLACE (city or town) Mobile
(State or country)

PARENTS

10 NAME OF FATHER William Joyner.

11 BIRTHPLACE OF FATHER (city or town) Mobile
(State or country) Ala.

12 MAIDEN NAME OF MOTHER Ella M. Griffin

13 BIRTHPLACE OF MOTHER (city or town) Mobile
(State or country) Ala.

14 Informant Ella M. Tannar (Mother)
(Address) Mobile Ala.

15 Filed MAY 10 1924 192 Robert F. Harris Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism
due history of accidental fall
and injury to scalp.
(duration) 1 yr
CONTRIBUTORY (Secondary) 2 days
(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
May, 192 4 (Address) (Coroner.) 1639 Barclay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., 1 mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Home. DATE OF BURIAL May 10 192 4

20 UNDERTAKER Lilly & Fils ADDRESS 402 Wolfe St

Burial Permit Sent

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86792

CERTIFICATE OF DEATH.

179 D 86792

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Roy M. Brown

(a) RESIDENCE NO 722 Marshall ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER L. M. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Bowie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant L. M. Brown
(Address) Bucksam Md

15 (Registrar's signature) ..... Registrar
Robert E. ... Jr.

MAY 1 01924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Oil Lamp Explosion

(duration) ..... yrs. ..... mos. 2 ds.

(Signed) H. R. Gonce, M. D.
(Coroner.)

5-10, 1924 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville, Md. Montgomery | DATE OF BURIAL 5-10 1924

20 UNDERTAKER E. & B. Hook | ADDRESS 115 E. North

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 86793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 86793

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 627 S 13th ..... St., 26 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Johannah C. Tyler

(Residence in Baltimore: No. 627 S. 13th St ..... St.; yrs., 3 ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. ..... Nov (Month) ..... 29 (Day) ..... 1863 (Year)

7-AGE. 60 yrs. 5 mos. 9 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ..... at home

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. James Tuley

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Julia Poole

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Daniel D. Tyler

(Address) ..... 627 S. 13th St

15-

Filed ..... 192.....

Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... May (Month) ..... 8 (Day) ..... 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M. Benson M. D.
(Coroner.)

May 9 1924 (Address) 707 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Cross C.A. Co.	5-12-24 1924

20-UNDERTAKER.	ADDRESS
E. B. Hark	115 E. West St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86794

CERTIFICATE OF DEATH.

100-09

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Wagner

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1851

7-AGE. 73 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer (?)

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ?
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ?
(State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAY 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-3-24

17- I HEREBY CERTIFY, That I attended deceased from 4-28, 1924 to 5-3, 1924 that I last saw h[illegible] alive on 5-2, 1924 and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration
Cerebral Hipplegia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat

(Signed) Claude G. Drane M. D.

5-3, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Patricks	5/9/24, 19....
20-UNDERTAKER,	**ADDRESS**
J J Fahey & Sons	1318 Eutaw

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86795

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86795

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 26 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Manuel Meni

(a) Residence No. Unknown St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single ?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1899

7-AGE.	If LESS than 1 day,
25 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Oiler 086

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): South America

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Hospital Records

(Address) M.T.H.

13- Filed MAY 1 01924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 3, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24 to May 3, 19 24, that I last saw him alive on May 3, 19 24, and that death occurred, on the date stated above, at 11.35 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Sputum and

What test confirmed diagnosis? Positive spinal fluid

(Signed) L. B. Lallo M. D.

5-4-24 19 (Address) Municipal Th[illegible] Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Pleasant	5/6/24, 19....
20-UNDERTAKER, J. J. Foley & Sons	ADDRESS 1318 Eight St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86796

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1948 W.Pratt St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate M. Whiteford

(a) Residence No. 1948 W.Pratt St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank C.Whiteford

6-DATE OF BIRTH (month, day and year) Mar. 26,1856

7-AGE,	If LESS than 1 day,
68 yrs. 1 mos. 12 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS.

10-NAME OF FATHER. Charles H.Bee

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. Harwood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Scotland

14- (Informant) Mrs.Chas.H.Cook

(Address) 1733 Hollins St.

15- Filed MAY 10 1924 Richard P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 8,1924

17- I HEREBY CERTIFY, That I attended deceased from March 27, 1924, to May 8, 1924, that I last saw h.. alive on May 7, 1924, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Cerebral Hemorrhage

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. D. Costelloe M. D.

5-9, 1924 (Address) 24 N.Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery. DATE OF BURIAL, May 12, 1924

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 W. Balto St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 86797

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 86797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4323 Belview ave ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Dobson

(a) RESIDENCE NO. 4323 Belview ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Dobson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hickory, Harford Co Md

PARENTS

10 NAME OF FATHER James McCroden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant L. B. Cook (Address) 1003 W Pratt St

15 Filed MAY 10 1924, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to May 9, 1924, that I last saw her alive on May 8, 1924, and that death occurred, on the date stated above, at 12:20 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Paralysis)

(duration) yrs. 4 hrs mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis & Senility

(duration 10 yrs. ~~4 hrs~~ mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Previous attendance

(Signed) C. B. Evson, M. D.

5-9, 1924 (Address) 5016 Park Hgts ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 12 1924
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 W Pratt St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86798

HEALTH DEPARTMENT—CITY OF BALTIMORE

114

D 86798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2202 Brookfield Ave Ward 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Babette Fechenbach

(a) Residence No.. 2202 Brookfield Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis Fechenbach

6-DATE OF BIRTH (month, day and year) May 28 1840

7-AGE. 83 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Germany

PARENTS.

10-NAME OF FATHER, Moses Straus

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophie Cahn

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Germany

14- (Informant) Mr. Sam Fechenbach

(Address) 2202 Brookfield Ave

15- Filed ..... 192.....
Robert P. MATTHEWS, Registrar.

MAY 1 0 1924

C-34 Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/9/24.

17- I HEREBY CERTIFY, That I attended deceased from 1/30 19 24 to 5/9 19 24

that I last saw her alive on 5/9/ 19 24

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Ulceration Colitis

(Duration) — yrs. 3 mos. 9 ds.

CONTRIBUTORY (Secondary).....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Examination of the Stool

(Signed) Harry Adler M. D

5/10. 1924 (Address) 1718 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Ohel Shalom Cem	5/11/ 1924.
20-UNDERTAKER.	ADDRESS.
David Sondheim	117-20 W. Mt. Royal Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86799

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Park Ave. ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie E. Parker

(a) RESIDENCE NO. 1819 Park ave. ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sewell Parker

6 DATE OF BIRTH (month, day, and year) Jan. 26th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Talbott Co. Maryland

PARENTS

10 NAME OF FATHER John Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co Maryland

12 MAIDEN NAME OF MOTHER Rhoda Sullivant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co Maryland

14 Informant Sewell Parker

(Address) 1819 Park Ave.

15 Filed MAY 10 1924, 19.... Robert E. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2nd. 1924, to May 8th. 1924, that I last saw her alive on May 8th, 1924, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

(Following Crisis)

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ... yrs. ... mos. 12 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Sanford Frey, M. D.

5/12, 1924 (Address) Cooks Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL May 12 1924

20 UNDERTAKER Fredk Lessahn & Sons — ADDRESS Belleview

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86800

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3242 Kingsley St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph L. Wiehen

(a) Residence No. 3242 Kingsley St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Henrietta Wiehen

6-DATE OF BIRTH (month, day and year) July 22, 1865.

7-AGE, 58 yrs. 9 mos. 16 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Bristle worker

(b) General nature of industry, business, or establishment in which employed (or employer)..... Wilkins Factory

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... New York
(State or Country).

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant)..... Herman Wiehen

(Address) 3242 Kingsley St.

15- MAY 1 0 1924 Robert P. Harris

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from January 1, 1924, to May 8, 1924,

that I last saw h... alive on May 7, 1924

and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

7 days

(Duration) ....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pul. Tuberculosis

(Duration) 1 yrs. ....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

5/8, 1924 (Signed) Wm. O'Neill M. D.

(Address) 108 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral | DATE OF BURIAL, May 12, 1924

20-UNDERTAKER, C. W. Dill | ADDRESS 3109 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86801

CERTIFICATE OF DEATH.

D 86801

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Mt Auburn ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Dorsey

(a) RESIDENCE NO. 1420 Mt Auburn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9/1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
		0		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — ~ Child

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer ~

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Robert Dorsey

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Hayneville Ala

12 MAIDEN NAME OF MOTHER Dorothy Harris

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Dorothy Dorsey (Address) 1420 McCulloh

15 MAY 7 1924, 19 Robert P. Harrison, Registrar

Cremated

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 24

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1924, to May 9th, 1924

that I last saw h alive on May 9th, 1924

and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

Septic Sore Throat

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Lee Ellis, M. D.

(Address) 924 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAY 10 19

20 UNDERTAKER: Commissioner Health, — ADDRESS

WARNING—RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86802

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3rd Av Fairfield ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigmund Heard

(a) RESIDENCE No. 3rd av Fairfield ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Heard

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fairfield Shipyard

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Edmond Heard

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unkn

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Jennie Heard (Address)

15 Robert J. [illegible]

MAY 1 01924 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 - 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7 - 1924 to May 8 - 1924 that I last saw h. alive on May 7 1924 and that death occurred, on the date stated above, at 5:45 PM

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Coleman M.D.

May 9. 1924 (Address) Dr 39 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	May 11 1924
20 UNDERTAKER	ADDRESS
Thos H. G. Elliott	722 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D 86803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-9 D 86803

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 657 Joseph Lane ST., 4 WARD)

2-FULL NAME Baby Hammond

(a) RESIDENCE NO. 657 Joseph Lane ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (Write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5/3/24

7 AGE: Years Months Days: 6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Catherine Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): Mother

15 Filed MAY 10 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/3, 1924, to 5/9, 1924, that I last saw h[illegible] alive on 5/9, 1924, and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 5/10/24 Thomas Lee, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 5-10 1924

20 UNDERTAKER: David Easton

ADDRESS: 916 Bo ane

WARNING—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86804 D 86804

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 N Gilmor St.; 19 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Hutka Ticky

(Residence in Baltimore: No. 219 N Gilmor St. 36 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. May 23, 1855 (Month) (Day) (Year)

7-AGE. 69 yrs. 11 mos. 17 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of Industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Austria

PARENTS.

10-NAME OF FATHER. Joseph Ticky

11-BIRTHPLACE OF FATHER (State or Country). Austria

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ticky

(Address) 219 N Gilmor St

12. MAY 10 1924 Robert P. Harrison, ..., 191..... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 9th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1924, to May 9th 1924, that I saw h[illegible] alive on May 9th 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart X

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

Renal

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. G. Smith M. D.

May 10, 191.. (Address) 118 N Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park

DATE OF BURIAL. May 11, 1924

20-UNDERTAKER. Edward Fulk

ADDRESS 1000 W Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86805

CERTIFICATE OF DEATH.

82 D 86805

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 892 W. Balto St. 16 WARD)

2-FULL NAME Salvatore Sansone

(a) RESIDENCE. No. 892 W. Balto St ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Concetta Sansone

6 DATE OF BIRTH (month, day, and year) 12/6/1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvatore Sansone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Geppi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Sam Sansone

(Address) 892 W Balto St

15 MAY 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 15 1924 to May 8 1924, that I last saw him alive on May 7 1924 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Multiple hemiti

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Smith M. D.

(Address) 4508 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	5/10 1924

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86806

D 86806

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dennis

(a) RESIDENCE No. 1221 E. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Dennis

6 DATE OF BIRTH (month, day, and year) June 14, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can maker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Valentine Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Carrie Morrow

(Address) 1221 East Preston St

15 Filed MAY 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 9, 1924, that I last saw him alive on May 9, 1924, and that death occurred, on the date stated above, at 12 20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Hypostatic Pneumonia
Anaemia

(duration) yrs. mos. ds.

Secondary Anemia

CONTRIBUTORY (Secondary) Epistaxis Ulcer rt side nasal Septum Arteriosclerosis Hypertension Chr. Endocarditis

(duration) yrs. mos. ds.

Chr. Nephritis

18 Where was disease contracted if not at place of death? 1221 E. Preston St.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Greg B. Seybert, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	5/13 1924
20 UNDERTAKER	ADDRESS
Henry W. Kears & Son	805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86807

CERTIFICATE OF DEATH.

90 D 86807

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 N. Chase ST., 11 WARD)

2-FULL NAME Margaret Brown

(a) RESIDENCE NO. 220 N. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Hans Brown

6 DATE OF BIRTH (month, day, and year) Apr 27, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Sam Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Samuel Brown

(Address) 220 N. Chase St

15 Filed MAY 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8. 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1924, to May 8th, 1924, that I last saw her alive on May 8th, 1924, and that death occurred, on the date stated above, at 12:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Hydronephrosis - Nephritis

Fracture (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? by Clinician

What test confirmed diagnosis?

(Signed) A. Lee Ellis M. D.

5/9, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 11, 1924
20 UNDERTAKER	ADDRESS
Chas H. Alexander	Greenmill Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86808 — 90 D 86808

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 443 E. Fort Ave. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benson F. Dill

(a) Residence No. 443 E. Fort Ave. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Laura V. Dill

6-DATE OF BIRTH (month, day and year) Dec. 16 1849

7-AGE. 74 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Oil Distributor
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R. R.
(c) Name of employer: 073

9-BIRTHPLACE (city or town) Md. (State or Country),

PARENTS:
10-NAME OF FATHER, James Dill
11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country).
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country).

11- (Informant) Mrs. Lang
(Address) 443 E. Fort Ave.

13- MAY 11 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/9/24

17- I HEREBY CERTIFY, That I attended deceased from 4/2 1924 to 5/9 1924, that I last saw h[illegible] alive on 5/9/24 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

General Debility 1 yr

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Amy Goldberg M D

5/10 1924 (Address) 2210 Gutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Ceme	5/12 1924
20-UNDERTAKER, J. Frew McCully	ADDRESS 130 S. Front

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Pks.

D 86809

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 15 74

City of BALTIMORE: (No. 4100 Groveland Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Edwin Dyott

(a) Residence No. 4100 Groveland Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-~~Single~~ Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Dyott

6-DATE OF BIRTH (month, day and year) Oct 12 1858

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Buyer for Weil & Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Centreville Md.

PARENTS.

10-NAME OF FATHER Samuel E. Dyott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER Henrietta Rozell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-

(Informant) Mary L. Dyott

(Address) 4100 Groveland Ave

15- MAY 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1923 to May 9, 1924

that I last saw him alive on May 9 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Fontanuaal Hemorrhage.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. G. Dunn, M. D.

, 19 (Address) 3501 Furrian Rd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loud Ridge DATE OF BURIAL, May 12 1924

20-UNDERTAKER John Antsetzel ADDRESS 22 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86810

CERTIFICATE OF DEATH.

D 86810

101-001

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

2-FULL NAME Daniel Shemer

(a) RESIDENCE No. 4003 Dalrymple ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	w	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 29-1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Greeery Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Morris Shemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Julia Yankelowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 Eldorado

15 Filed MAY 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/9, 1924, to 5/10, 1924, that I last saw him alive on 5/10, 1924, and that death occurred, on the date stated above, at 11 a, m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary) Emphysema + contracted pneumonia (?)

(duration) ..... yrs. ..... mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Apr 17, 1924

Was there an autopsy? no

What test confirmed diagnosis? clinical, lab. + operation

(Signed) Isidor S. Fry, M. D.

May, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	May 11 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eldorado

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 86811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86811

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 2101 E. Baltimore St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bailey Brestin

(a) Residence No. 2101 E. Balto St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, White

5-Single, Married, Widow, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Meyer Brestin

6-DATE OF BIRTH (month, day and year) Unk Com

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Balto St

15- FILED MAY 11 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 10 24

17- I HEREBY CERTIFY, That I attended deceased from June 1922 to May 10 1924, that I last saw h.. alive on May 10 1924, and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis & Hypertension

(Duration) 2 yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel White Love M. D

, 19 (Address) 610 Easton Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Friendship	May 11, 1924
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1439 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86812

CERTIFICATE OF DEATH.

90 D 86812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3937 Boerman ave ST., 15 WARD)

2-FULL NAME Alda Friedman

(a) RESIDENCE NO. 3937 Boerman ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Friedman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Borel Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eutaw St

15 MAY 1 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10 19 2x

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 19 2x, to 5/10, 19 2x.

that I last saw her alive on 5/10, 19 2x.

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H Winters, M. D.

5/10, 19 2x (Address) 1826 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Washington Rd

DATE OF BURIAL 5/11 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

86813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86813

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Hebrew Hospital ST., ... WARD)

2-FULL NAME Sarah Wolf

(a) RESIDENCE NO. 30 N. Patterson Park Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Wolf

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Isaacs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon Wolf
(Address) 30 N. Patterson Pk Ave

15 Filed MAY 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) ..... yrs. ..... mos. 6 hrs.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. H. Paul, M. D.
(Coroner.)

May 10/24 192 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leitums Southern

DATE OF BURIAL 5/11 1924

20 UNDERTAKER A. Lehmann & Bro

ADDRESS 112 E Balto

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86814

CERTIFICATE OF DEATH.

153 D 86814

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Kraft.

(a) RESIDENCE NO. 1047 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 27 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore - Md

PARENTS

10 NAME OF FATHER Clarence Kraft

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Grace Seipp

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Grace Kraft

(Address) 1047 S Charles st

15. Filed MAY 11 1924 ROBERT R. KRAMER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/ 1924.

17 I HEREBY CERTIFY, That I attended deceased from 5/8/, 1924, to 5/10, 1924.

that I last saw her alive on 5/10/, 1924.

and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Cervical abscess.

Rachitis (severe).

Severe sordam anaemia.

Uncertain (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis, Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? Yes Date of 5/8/24

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John M. Edmonds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL WESTERN CEMETRY

DATE OF BURIAL 5/12 1924

20 UNDERTAKER ROBERT BROOKS & SON

ADDRESS COR CALHOUN HOLLINS ST

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86815

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1116 N. Charles Street

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Clifton

(a) RESIDENCE NO. 1116 N. Charles ST., 11 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook - Ord
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer M. B. Berglund

9 BIRTHPLACE (city or town) Lexington-Ky
(State or country)

PARENTS

10 NAME OF FATHER Johnson Clifton

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Harriet Grant

13 BIRTHPLACE OF MOTHER (city or town) Kentucky
(State or country)

14 Informant Madell Brown
(Address) 1718 Druid Hill Ave.

Filed MAY 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 10, 1924, that I last saw h[illegible] alive on May 10, 1924, and that death occurred, on the date stated above, at 11 40 pm.

The CAUSE OF DEATH* was as follows:

Angina pectoris - Arteriosclerosis - Fatty Cerebral apoplexy. (Death sudden - Has been working all day (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) - Was found sitting in chair (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John McF. Berglund, M. D.

, 19 (Address) 4 W. Biddle Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lexington Cem	May 12 1924
20 UNDERTAKER	ADDRESS
Frank H. Hemsley	W. Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86816

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4110 Roland Ave (St.) (Ward) 13

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia Cox Hood

(a) RESIDENCE NO. 4110 Roland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Charles W. Hood

6 DATE OF BIRTH (month, day, and year) Sept 19 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hayfordsferry W Va

PARENTS

10 NAME OF FATHER James Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va

12 MAIDEN NAME OF MOTHER Rebecca M Fadeus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant (Address) Mrs Alice Hood 4110 Roland Ave

15 MAY 11 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 , 1923 , to May 10 , 1924 ,

that I last saw her alive on May 9 , 1924 ,

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) R L B Norment, M. D.

(Address) 3343 Chelsea Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudan Park — DATE OF BURIAL May 12 1924

20 UNDERTAKER A S Marshall — ADDRESS 3539 Fdk Rd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86817

D 86817

CERTIFICATE OF DEATH

11-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 Rookwood Ave ST., Ellerslie (WARD) 7

2-FULL NAME Lucie Lee Santmyer

(a) RESIDENCE No. 120 Rookwood Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 23 - 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	19	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 068

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER T. Clayton Santmyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie H. Santmyer (Address) 120 Rookwood Ave

15 Filed MAY 1 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/9 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/3, 1924, to 5/9, 1924, that I last saw her alive on 5/8, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Influenza, arteriosclerosis, pericarditis endocarditis, secondary pneumonia ×

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Turnbull, M. D.

5/10, 1924 (Address) 3902 Loreland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 5/12 1924

20 UNDERTAKER Chas. B. Braustein

ADDRESS 118 W. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86818

D 86818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 800 Belgian Ave

CITY OF BALTIMORE: (No. Baltimore Md. St.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Stuart Rehm

(a) RESIDENCE. No. 800 Belgian Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 25, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph M. J. Rehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant ~~the~~ Brother
(Address) Baltimore Md

15 Filed MAY 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1924

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1924, to May 9, 1924, that I last saw him alive on May 9, 1924, and that death occurred, on the date stated above, at 7:50 A m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) George C Medairy, M. D.

, 19 (Address) 3304 Gilmor Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Marys Groves — May 12 1924

20 UNDERTAKER — ADDRESS

J. C. Medairy — 9 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

131

D 86819

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 Rosedale ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Lee

(a) RESIDENCE NO. 1817 Rosedale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Lee

6 DATE OF BIRTH (month, day, and year) March 17 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Wm H Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mc Kenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Alice Lee

(Address) Rosedale

MAY 11 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to to May 9, 1924, that I last saw him alive on May 9, 1924, and that death occurred, on the date stated above, at 9 50 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory paralysis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bilateral pyelonephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? not done

What test confirmed diagnosis? ureteral catheter specimen

(Signed) DeWallenstein, M. D.

, 19 (Address) 2042 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	5/12 1924
20 UNDERTAKER	ADDRESS
George A Farley	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86820

CERTIFICATE OF DEATH.

45 D 86820

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1526 N. Carolina St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Kraber

(a) Residence No. 1526 N. Carolina St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma L. Kraber

6-DATE OF BIRTH (month, day and year) Jan. 6/1859

7-AGE. 65 yrs. 4 mos. 3 ds. If LESS than 1 day, ~~hrs.~~ or ~~min.~~?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired 034
(b) General nature of industry, business, or establishment in which employed (or employer) Grocer
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frederick Kraber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Annie Stumpf

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Emma L. Kraber
(Address) 1526 N. Carolina St

15- Filed MAY 11 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9 1924.

17- I HEREBY CERTIFY, That I attended deceased from May, 19 22 to May 9 19 24
that I last saw h. alive on May 9 19 24
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 2 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary odema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Wm O Smith M. D

5/10 192 (Address) 3929 Chestnut St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery.	May 12, 1924
20-UNDERTAKER,	ADDRESS
George J. Ruth	1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86821

CERTIFICATE OF DEATH.

D 86821

REGISTERED NO. 179

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Jones

(a) RESIDENCE NO. 1619 N. Castle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Jennie Jones

6 DATE OF BIRTH (month, day, and year) Jan. 21 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mayard O'Neill

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs Jennie Jones

(Address) 1619 N. Castle St

15 Filed MAY 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY That I attended deceased from May 10, 1924, to May 10, 1924, that I last saw him alive on May 10, 1924, and that death occurred, on the date stated above, at 9:05P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 14

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Clayton Vandiver M. D.

, 19 (Address) Edmondson Avenue and Bentz

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral cemetery — DATE OF BURIAL May 14 1924

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86822

CERTIFICATE OF DEATH.

90 ✓ D 86822

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 558 W. Preston ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson A. Bunke

(a) RESIDENCE NO. 558 W. Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Bunke

6 DATE OF BIRTH (month, day, and year) Sept 17- 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	72	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fred. Slouman

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George J. Bunke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eleanor Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Florence Bunke

(Address) 558 W Preston St

15 MAY 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to May 8, 1924,

that I last saw h in alive on May 8, 1924,

and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

Indefinite (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman, M. D.

May 10 1924 (Address) 708 Mulberry Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 12, 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostend St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86823

CERTIFICATE OF DEATH.

90 D 86823

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 529 N. Longwood St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Cusick

(a) Residence No. 529 N. Longwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of - Martin Cusick

6-DATE OF BIRTH (month, day and year) Unknown.

7-AGE.	If LESS than 1 day,
57 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home work.

(b) General nature of Industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Michael Cusick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Mrs. Martin Cusick

(Address) 529 N. Longwood St.

15- Filed MAY 9 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2 1924 to May 9 1924

that I last saw her alive on May 9 1924

and that death occurred, on the date stated above, at 1 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO ( )

What test confirmed diagnosis? Clinical

(Signed) D. J. Hennessy M. D.

May 10, 1924 (Address) 280 Edmondson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: May 12 1924

20-UNDERTAKER: Peter F. Cowan & Son ADDRESS: 90 Holliday St.

Peter F. Cowan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 V D 86824

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 N Mount ST., 19 WARD)

2-FULL NAME Lillie Scott

(a) RESIDENCE No. 12 N Mount ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General House work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James H. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co Md

12 MAIDEN NAME OF MOTHER Anna Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co Md

14 Informant (Signature) Jos Scott (Bro)
(Address) 14 N Mount St

15 MAY 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 9 1924, that I last saw her alive on May 9 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Edema of Vagina (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Walter J. Dorsey, M. D.

, 19 (Address) 1618 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 12 1924
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N. Schroeder St

Spec—12-23-21—E.B.R.S.—400 Eks.

D 86825

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 225 Cedar St West Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neptune B. Griffith

(a) Residence No. 225 Cedar St West Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, ~~widowed, DIVORCED~~ or (or) WIFE of E. Stanley Griffith

6-DATE OF BIRTH (month, day and year) Dec 26 1848

7-AGE. 75 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Penn. Pa.

PARENTS.

10-NAME OF FATHER. William M. Corman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Penn Pa.

12-MAIDEN NAME OF MOTHER, Sarah Kemp

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Penn Penn

14- (Informant) E. Stanley Griffith

(Address) 225 Cedar St. West Husband

15- Filed MAY 1 2 1924 OWEN I. R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 10-1924

17- I HEREBY CERTIFY, That I attended deceased from 3 May, 1924, to 9 May, 1924, that I last saw h[illegible] alive on 9 May, 1924, and that death occurred, on the date stated above, at 7-40 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Acute —

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Wadsworth M. D.

, 19 (Address) Baltimore Md

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Hill Ave

DATE OF BURIAL. May 13 1924

20-UNDERTAKER. H. M. Cook

ADDRESS 502 E. Pr. Ave.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36826

CERTIFICATE OF DEATH.

11

D 36826

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME Mrs Celia Van Tine

(a) RESIDENCE NO. 1811 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry C. Van Tine

6 DATE OF BIRTH (month, day, and year): Jan 5 1853

7 AGE: Years 71 Months 4 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pittsburg Pa

PARENTS

10 NAME OF FATHER: David Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pittsburg Pa

12 MAIDEN NAME OF MOTHER: Harriet Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pittsburg Pa

14 Informant: Howard Sutton

(Address): South & Water Sts

15 Filed MAY 1 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-10-1924

17

I HEREBY CERTIFY, That I attended deceased from 4/30/24, 19, to 5/10/24, 19.

that I last saw her alive on 5/10/24, 19.

and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary): Bronchial pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/30/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Pabst, M. D.

, 19 (Address) Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 12 1924

20 UNDERTAKER: Wm Brook — ADDRESS: 502 E Monument

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86827

CERTIFICATE OF DEATH.

11-001 D 86827

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2753 Maryland Ave ST.; 17 WARD)

2-FULL NAME Laura J. Gattin

(a) RESIDENCE. No. 2753 Maryland Ave ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales lady

(b) General nature of industry, business, or establishment in which employed (or employer) Dept Store

(c) Name of employer Hutzler Bros

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER Charles E. Gattin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago Ill

12 MAIDEN NAME OF MOTHER Eliza J. Mullikin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lizzie Gattin

(Address) 2753 Maryland Ave

MAY 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 19, to May 9 19 24,

that I last saw h.. alive on May 8 19 24,

and that death occurred, on the date stated above, at 3. A. m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) ... yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Senile myocarditis

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George M. Sepp, M. D.

May 9 1924 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: May 12 1924

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 902 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86828 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 D 86828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 434 Aisquith St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Sobal

(a) Residence No. 434 Aisquith St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 11-24

7-AGE. .....yrs.....mos.....ds. If LESS than 1 day, 9 hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country),

PARENTS

10-NAME OF FATHER, Louis Sobal

11-BIRTHPLACE OF FATHER (city or town) Russia
(State or Country).

12-MAIDEN NAME OF MOTHER Rebecca Rosenthal

13-BIRTHPLACE OF MOTHER (city or town) Russia
(State or Country).

14- (Informant).....

(Address) 434 Aisquith St

15- Filed..... 192.... ROBERT R. KRAUTER, Registrar.

MAY 12 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12-24

17- I HEREBY CERTIFY, That I attended deceased from May 11 1924 to May 12 1924 that I last saw him alive on May 12 1924 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Baughman M. D

5/12, 1924 (Address) 710 Aisquith

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Rebecca Mt Carmel	5/12, 1924
20-UNDERTAKER.	ADDRESS.
Jack Levin	1439 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 86829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86829

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 18 S. Bond St ..... St., 2 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dohie Lieben

4 (a) Residence No. 18 S. Bond St ..... St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Lieben

6-DATE OF BIRTH (month, day and year) —

7-AGE. 30 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, bnsiness, or establishment in which employed (or employer)..... 03

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E Balto St

15- MAY 1 2 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 11 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1924 to May 11 1924

that I last saw her alive on May 10 1924

and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) acute dilatation of Heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Silverstein M. D

, 19 (Address) 22 S. Wood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Northern circle Cem	5/12 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1409 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

Hochmal

D 86830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2332 Eager Place ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hohmal

(a) RESIDENCE No. 2332 Eager Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Hohmal

6 DATE OF BIRTH (month, day, and year) July 22, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker 014

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gunther & Sons

9 BIRTHPLACE (city or town) (State or country) Czecho-slovakia

PARENTS

10 NAME OF FATHER John Hohmal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-slovakia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Charles Hohmal

(Address) 2347 Eager Place

Filed MAY 12 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1924, to May 10, 1924.

that I last saw him alive on May 10, 1924

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vincent V. Jonka, M. D.

, 19 (Address) 845 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL May 13 1924

20 UNDERTAKER Ernest Crook & Son — ADDRESS 1906 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H/H D 86831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Jefferson ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua Dennis

(a) RESIDENCE NO. 1505 Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Jane Dennis

6 DATE OF BIRTH (month, day, and year) year 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER William Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriett Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hester Hudson 1505 Jefferson St

Filed MAY 12 1924 Burial Permit Issued. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1924, to May 10, 1924, that I last saw him alive on May 9, 1924, and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma.

(duration) unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Q. ..., M. D.

5/10 1924 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	5/13/24
20 UNDERTAKER Thorton White	ADDRESS 113 S Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. George W. Linder

86832

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 86832

CERTIFICATE OF DEATH.

8 74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1723 Clifton ave St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... George W. Lindner

(a) Residence No.... 1723 Clifton ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 20 1861

7-AGE, 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Denmark.

PARENTS.

10-NAME OF FATHER, G. V. Lindner

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Denmark

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Denmark.

14- (Informant) Anita J. Linder

(Address) 1723 Clifton Ave

15- Filed MAY 12 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 10 - 1924

17- I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to May 10, 1924, that I last saw him alive on May 10, 1924, and that death occurred, on the date stated above, at 2 P. m. The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No clinical

What test confirmed diagnosis?

(Signed) F. J. Kemper, M. D.

5/12, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, May 13, 1924

20-UNDERTAKER Robt J Turner — ADDRESS 1442 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86833

CERTIFICATE OF DEATH.

11-602

D 86833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 W. Hamburg ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Seipp

(a) RESIDENCE NO. 711 W. Hamburg ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Seipp

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	77	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gottlieb Storz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna E. Winkenstaad

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Gotlieb Seipp

(Address) 711 W. Hamburg St

15 MAY 12 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1924, to May 10 1924, that I last saw h[illegible] alive on May 9th, 1924, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

La Grippe

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Senile Decay

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. Emerson, M. D.

5/12, 1924 (Address) 517 Lovedale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Conn	May. 13 1924
20 UNDERTAKER	ADDRESS
Mr. Mrs. Jno. F. Teufel & Son	801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86834 38 D 86834

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital No Registered No.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fogan Frohen

(a) Residence No. Unknown St., ... Ward.....

(Usual place of abode) Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Blk

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1873

7-AGE, 51 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 08

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Do

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do

12-MAIDEN NAME OF MOTHER, Do

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do

14- (Informant) Bay View Hospital

(Address) .....

15- (Filed) MAY 1 2 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 20, 1922 to May 8, 1924

that I last saw him alive on May 7, 1924

and that death occurred, on the date stated above, at 2.40 p.m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Contributory

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Serological

(Signed) H. Goldsmith M. D.

5/10, 1924 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, ... 19....

20-UNDERTAKER, Commissioner Health. ADDRESS MAY 10 1924

FOR FRS. S. WOODALL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86835

CERTIFICATE OF DEATH.

161-001 D 86835

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hoplins Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Girl) Krug

(a) RESIDENCE NO. 2702 O'Donnelle St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	About	24 hrs	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Krug

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Selma ------

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Johns Hopkins Hospital
(Address) JOHNS

15 Filed MAY 12 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

Autopsy at Hospital

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner.)

May 7 24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL MAY 12 1924

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86836

CERTIFICATE OF DEATH.

188-007
D 86836
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: [redacted] 4900 Blk. Park Heights Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Kull

(a) RESIDENCE NO. 4911 Park Heights Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. -- mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick Kull

6 DATE OF BIRTH (month, day, and year) April 13 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	0	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Dress Maker
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Christoph Siemon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Heer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wilhelmina Wagner
(Address) 4911 Park Heights Ave.

15 Filed MAY 12 1924 ROBERT R. KRASTER, Burial Permit Clerk, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Street Car Accident

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) , M. D.
(Coroner)

May 11, 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 12 1924

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

86837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86837

1-PLACE OF DEATH University Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 28 WARD)

2-FULL NAME Harry Smith

(a) RESIDENCE NO. 4100 Gorsuch Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21/1910

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
13	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER H C Smith

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ann Cantley

13 BIRTHPLACE OF MOTHER (city or town) West Va
(State or country)

14 Informant Geo Mosser
(Address) 1442 N Gay St

15 MAY 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/24 19

17 I HEREBY CERTIFY, That I attended deceased from 5/8/24, 19..., to 5/11/24, 19...

that I last saw him alive on 5/11/24, 19...

and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Brain Tumor.

(duration) ..... yrs. ..... mos 30 ds. ?

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto Md.

Did an operation precede death? Yes Date of 5/10/24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings + X ray

(Signed) Wm Doub Jr. M. D.

, 19 (Address) Univ Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 13, 1924
20 UNDERTAKER Geo Mosser	ADDRESS 1442 N Gay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86838 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 86838

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 N. Milton Ave St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie L. Schaaf

(a) Residence No. 916 N. Milton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: White | 5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: John Schaaf

6-DATE OF BIRTH (month, day and year): Dec 27/84

7-AGE: 39 yrs. 4 mos. 14 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS

10-NAME OF FATHER: John Wagner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): John L. Schaaf

(Address): 916 N. Milton Ave

15- MAY 12 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 5/11/24

17- I HEREBY CERTIFY, That I attended deceased from April 5 = 1924 to May 11 = 24.

that I last saw h.. alive on May 10 = 24.

and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

.....(Duration) yrs. 1 mos. 8 ds.

CONTRIBUTORY (Secondary)

.....(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Signed: H. A. Meyer M. D.

5/12, 1924 (Address) 1031 N. Calvert St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel | DATE OF BURIAL: 5/14, 1924

20-UNDERTAKER: Philip Herrig | ADDRESS 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 86839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86839

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2421 Arunah Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Eagleston

(a) Residence No. 2421 Arunah Ave St., ... Ward, ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE late Geo. J. Eagleston

6-DATE OF BIRTH (month, day and year) Jan 3/61

7-AGE. 63 yrs. 4 mos. 6 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer .....

9-BIRTHPLACE (city or town) City
(State or Country),

PARENTS.

10-NAME OF FATHER, John Carr

11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country),

12-MAIDEN NAME OF MOTHER Elizabeth —

13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country),

14- (Informant) Edith C. Eagleston

(Address) 2421 Arunah Ave.

15- MAY 1 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/9/24

17- I HEREBY CERTIFY, That I attended deceased from 4/28/24 19..... to 5/9/24 19 24

that I last saw h.. alive on 5/8/24 19.....

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease —
Diabetes —

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. S. Gray M. D

5/11/24 (Address) 6 W Mt Vernon Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Balto Cem	5/12, 1924
20-UNDERTAKER	**ADDRESS**
Philip Herwig	2016 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Blks.

D 86840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2409 Druid Hill Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Daisy Rogers

(a) Residence No. 2409 Druid Hill Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Cd

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Rodgers

6-DATE OF BIRTH (month, day and year): July 12-1892

7-AGE, 34 yrs. 9 mos. 28 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of Industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va

PARENTS.

10-NAME OF FATHER: Washington Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Jennie Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14-
(Informant): Walter Rodgers
(Address): 2409 Druid Hill

15-
Filed ..... 192. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MAY 12 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 9-24

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 9, 1924, that I last saw h.r alive on May 9, 1924, and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Dysentries

(Duration) 7 yrs. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Stamm test

(Signed) J C Stewart M. D.

(Address) 704 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Eastern Bur. Acona Md Va. DATE OF BURIAL, 5/12/24

20-UNDERTAKER: Helen A. Holland ADDRESS 1631 Druid Hill Avenue

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86841

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 13 WARD)

2-FULL NAME Edith Colbert

(a) RESIDENCE No. 2540 McCulloh St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ignatius

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm H. Toney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mable Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 21 1924, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to May 10, 1924, that I last saw her alive on May 10, 1924, and that death occurred, on the date stated above, at 12 10 P m.

The CAUSE OF DEATH* was as follows:

Proctitis (cause unknown)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pylephlebitis and multiple liver abscesses (duration) yrs. mos. 20 da.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL 5/14/24

20 UNDERTAKER Helen A. Holland — ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 86842

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-09 D 86842

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Helen Hospital ST., 3 WARD)

2-FULL NAME Gladys Lapidus

(a) RESIDENCE No. 37 Floyd St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 6 mos. — ds. How long in U. S., if of foreign birth? 5 yrs. 6 mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Morris Lapidus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Berman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Bessie Lapidus
(Address) 37 Floyd st

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar
MAY 12 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1924, to 5-12, 1924, that I last saw h[er] alive on 5-12, 1924, and that death occurred, on the date stated above, at 320A m.

The CAUSE OF DEATH* was as follows:

Acute Myelogenous Leucheamia

(duration) ..... yrs. ..... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. C. Y. Cohen M. D.

5/12, 1924 (Address) Johns Hop.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dubuar Friendship — DATE OF BURIAL 5/12 1924

20 UNDERTAKER S. Levinson & Bro — ADDRESS 1121 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86843

CERTIFICATE OF DEATH.

REGISTERED No. C 90 D 86843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 High alley ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Henderson

(Residence in Baltimore: No. 1213 High alley St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 70 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Neal

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Liza Scott

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W Henderson

(Address) 1502 E Monument

15-

MAY 12 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit C[illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 9, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1924, to May 9 1924, that I saw her alive on May 8 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Cardiac decompensation

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Septic Tonsilitis

(Duration) ....yrs. ....mos. 14 ds.

(Signed) R Young M. D.

5/9, 1924 (Address) 1422 E Monument

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury — DATE OF BURIAL, May 14 1924

20-UNDERTAKER John D Henderson — ADDRESS 1502 E Monument

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86844

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 86844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1335 E Clement St. 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Duffy

(a) Residence No. 1335 E. Clement St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. - mos. - ds. How long in U. S., if of foreign birth? 43 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Duffy

6-DATE OF BIRTH (month, day and year) May 2 1861

7-AGE.	If LESS than 1 day,
63 yrs. mos. 9 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Retired

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Martin Duffy

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Leary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Mary Duffy

(Address) 1335 E Clement St

15-

MAY 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May. 10, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10th. 24 to May 10 24

that I last saw h.. alive on May 10 24

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart 1 hr

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) 1 yrs. - mos. - ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos F. Stevens M. D

5/11 . 1924 (Address) 2878 Hartford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	May 13, 1924
20-UNDERTAKER. Chas L. Stevens	ADDRESS 1501 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86845. HEALTH DEPARTMENT—CITY OF BALTIMORE D 86845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 3544 Benson St. Ward 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J. Shipley

(a) Residence No. 3544 Benson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: White

5-Single, Married, or Divorced, (Write the word): Married

5a-If married, widowed or divorced HUSBAND of (or WIFE): Robert Shipley

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (City or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country): Unknown

14- (Informant): Howard Chelcon

(Address): 3544 Benson St.

15- Filed 1924 ROBERT R. KRAUTER Registrar.

MAY 12 1924

Burial Permit No. 4

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 11 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 15th, 1923, to May 11th, 1924, that I last saw her alive on May 10th, 1924, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Arterio-sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema lungs

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Thos. Underwood, M. D.

5/12, 1924 (Address) 846 W 36th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL, May 13 1924

20-UNDERTAKER, Chenoweth & Son

ADDRESS 2417 Gilmor St. Ave.

CHENOWETH & SON, 2417 GILMOR ST. AVE.

N. B.—WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

MARY JONES

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86846

CERTIFICATE OF DEATH.

10 90

D 86846

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Jones

(a) Residence No. Preston & Caroline St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Martin Jones.

6-DATE OF BIRTH (month, day and year) January 1848

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Henry Kettler.

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Isabella Ashler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant). Sister F. Germaine

(Address) Preston & Caroline

15- Filed MAY 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 11/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 8 1923, 19....., to....., 19.....,

that I last saw h.m. alive on May 4, 1924,

and that death occurred, on the date stated above, at 1.20 m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Unknown (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) F. O'Donovan, M. D.

May 11, 1924 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL, May 12 1924

20-UNDERTAKER. H C Wedefeld ADDRESS 914 Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86847

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 531 Rossiter Ave St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kerley

(a) Residence No. 531 Rossiter Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

3a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 1856

7-AGE, 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home 68

(b) General nature of industry, business, or establishment in which employed (or employer) School Teacher

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Daniel Kerley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) H C Wiedefeld

(Address) 914 Fremont Ave

15-

Filed ..... 192 ..... HUGH R. KRAUTER, Registrar.

MAY 12 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 10-1924

I HEREBY CERTIFY, That I attended deceased from ....., 1915..., to May 10....., 1924

that I last saw her alive on May 10....., 1924

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

Mitral Insufficiency

.....(Duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

.....(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Stethoscope

(Signed) Mary F. Voegelein, M. D.

5.12, 1924 (Address) 1028 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	May 14 1924
20-UNDERTAKER.	ADDRESS
H C Wiedefeld	914 Fremont Ave

INSTRUCTIONS: THIS BLANK WHEN FILLED OUT BECOMES A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86848

CERTIFICATE OF DEATH.

162 D 86848

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Rabora ST., 4 WARD)

2-FULL NAME Baby Boy Chesley

(a) RESIDENCE NO. 702 Rabora ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 8th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Louis Jackson

11 BIRTHPLACE OF FATHER (city or town) A. A. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Chesley

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co.
(State or country) Md.

14 Informant Mrs Chesley
(Address) 702 Rabora

15 Filed MAY 12 1924 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1924, to May 11th, 1924, that I last saw him alive on May 10th, 1924, and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prolonged labor

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis T. Douglass, M. D.

5-12 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL H. Hebron

DATE OF BURIAL 5-12 1924

20 UNDERTAKER Sam'l H. Cole Son

ADDRESS 1400 Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86849

CERTIFICATE OF DEATH.

161-00 D 86849

1-PLACE OF DEATH

City of BALTIMORE; (No. 1622 Gilmore St., 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Etta Pate

(a) Residence No. 1622 Gilmore St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. Fe

4-COLOR OR RACE, Wh

5-Single, Married, Widowed, or Divorced, (Write the word.) Wife

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 9, 1844

7-AGE, yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS

10-NAME OF FATHER, James Pate

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Harford Co Md

12-MAIDEN NAME OF MOTHER, Mary Etta Grantz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) James Pate

(Address) 1622 Gilmore St

15- ROBERT R. KRAUTER, Burial Permit Clerk.

MAY 12 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 11 1924

17- I HEREBY CERTIFY, That I attended deceased from May 11—1924 to May 11, 1924

that I last saw h— alive on May 11, 1924

and that death occurred, on the date stated above at 5-P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth—Due

Premature Birth, Unknown

Period of Utero Gestation

(Duration) about 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. Garland Dunbar M. D.

May 11, 1924 (Address) 1534-20 St Can

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
HOPKINS HOSPITAL	MAY 12 1924 19....
20-UNDERTAKER. Commissioner Health,	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1,49

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86850

CERTIFICATE OF DEATH.

90

D 86850

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 904 E. 38th St. ST., 13 WARD)

2-FULL NAME William H. Arthur, Sr.

(a) RESIDENCE NO. 904 E. 38th St. ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A. Arthur

6 DATE OF BIRTH (month, day, and year) Nov. 11-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist 231
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 years
(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Arthur

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Lyndemore

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Alex C. Arthur
(Address) 904 E. 38th St.

15 Filed MAY 1 2 1924, 192.... Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry), find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrison, M. D.
(Coroner.)

May 12 '24 (Address) 502 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 13 1924
20 UNDERTAKER Horace F. Burgee	ADDRESS 363 Park Road

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86851

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D 86851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 Morling Ave St., 43 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ellen Plowman

(a) Residence No. 1312 Morling Ave St., 43 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew J. Plowman

6-DATE OF BIRTH (month, day and year): Aug 26-1836

7-AGE: 87 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Carroll Co. Md.

PARENTS.

10-NAME OF FATHER: Richard Hager

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Armacost

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Miss Emma Plowman

(Address): 1312 Morling Ave

15- Filed MAY 7 1924, 19.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 10-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 21, 1924, to May 10, 1924, that I last saw h... alive on May 9, 1924, and that death occurred, on the date stated above, at ...p.m.

The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry E. Alyea, M. D.

May 13, 1924 (Address) 3449 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet, Hampden — DATE OF BURIAL: May 13, 1924

20-UNDERTAKER: Howard A. Burgee — ADDRESS: 3631 Falls Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 70

City of BALTIMORE: (No. 2105 Barclay St. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katherine V. Meridith

(a) Residence No. 2105 Barclay St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct. 6-1920

7-AGE, 3 yrs. 7 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer). 0 0

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Walter T. Meridith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N. Va.

12-MAIDEN NAME OF MOTHER. Florence G. Mules

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-

(Informant). Charles N. Mules

(Address) 2105 Barclay St.

15-

Filed MAY 12 1924, 19?

Robert P. Harrison, Registrar.

Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 10-1924

17- I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to May 10, 1924,

that I last saw h.. alive on May 10, 1924

and that death occurred, on the date stated above, at 7 18 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Encephalitis Lepundatis

(Duration) yrs. mos. 1 5 ds.

18-Where was disease contracted if not at place of death? 0 0

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Franklin, M. D.

, 19 (Address) 4037 Falls Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Mary's (Hampden) — DATE OF BURIAL. Aug. 13, 1924

20-UNDERTAKER. Horace H. Burgee — ADDRESS 363 Falls Road

MAY 12 1924

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. USE WHITE PENCIL, WITH UNFADING INK—THIS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86853

CERTIFICATE OF DEATH.

1729

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2623 Lebanon St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hardy

(a) Residence No. 2623 Lebanon St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 5m mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Wh

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of David Hardy

6-DATE OF BIRTH (month, day and year) Dec 27 1843

7-AGE. 81 yrs. 4 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) ..... (State or Country). Md

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country). Germany

14- (Informant) Mrs J Fuller

(Address) 2623 Lebanon St

15- Filed 5/12/24 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 11 1924.

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 11 1924

that I last saw h.. alive on May 10 1924

and that death occurred, on the date stated above, at 3 11 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) W. A. Powell, M. D.

5/12, 1924 (Address) 2623 Lebanon St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery DATE OF BURIAL. May 13 1924

20-UNDERTAKER. Leo L. Schwartz ADDRESS 101 Fredk. Ave.

IMPORTANT! WITH UNFADING INK. Every item of the certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No.) St. Agnes Hospital St. 25 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaretta A Beadle

(a) Residence No... Biltmore NC St.,..... Ward Biltmore N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Chauncy D Beadle

6-DATE OF BIRTH (month, day and year) Sept. 25-1868

7-AGE, 55 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, John Hetzel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), America

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Chauncy D Beadle

(Address) Biltmore N C

15- Robert P. Harrison

16- Registrar.

MAY 12 1924

Burial Permit filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 11-24

17- I HEREBY CERTIFY, That I attended deceased from May 6 1924 to May 11 1924

that I last saw h.. alive on May 11 1924

and that death occurred, on the date stated above, at 9.40 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Metastases

(Duration) yrs. 9 mos. ds.,

CONTRIBUTORY (Secondary) Scirrhous Carcinoma Breast (Duration) 2 yrs. mos. ds.)

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes (Removal of Breast) Date of 4/17/22

Was there an autopsy? No

What test confirmed diagnosis? Lab & Phys Fdgs

(Signed) H V Harper M. D

, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Biltmore N. C. DATE OF BURIAL. May 17 1924

20-UNDERTAKER George L. Schmidt ADDRESS 1101 Eutaw Pl.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86855 ✓ D 86855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1461 Woodall ST. 24 WARD) 45

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Abel

(a) RESIDENCE. NO. 1461 Woodall ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John Abel

6 DATE OF BIRTH (month, day, and year) Mar. 14. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator. 069

(b) General nature of Industry, business, or establishment in which employed (or employer) Clothing factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Frances Abbes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain.

12 MAIDEN NAME OF MOTHER Sonia Lowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Md.

14 Informant Wm. Abbes. (Address) 1461 Woodall.

15 [illegible] Robert F. Harrison, 19 Registrar

MAY 1 21924

[illegible] Deputy Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924.

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1923, to May 10, 1924, that I last saw h[illegible] alive on May 8, 1924, and that death occurred, on the date stated above, at 6[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Seabury, M. D.

5/10 1924 (Address) 638 Fort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Annap Rd.	May 14, 1924
20 UNDERTAKER	ADDRESS
Fred A. Krause & Son.	703 Hanover St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 86856 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ of D 86856

CERTIFICATE OF DEATH. 100

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. St. Agnes Hosp. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Eckert

(a) Residence No. 825 S. Port St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): April 1876

7-AGE: 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Do not know

12-MAIDEN NAME OF MOTHER: Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Do not know

11- (Informant): Mrs Johanna Stuney

(Address): 825 S. Port St

15-

Filed: Robert P. Harris, Registrar.

Y 12 192

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 5-11-24

17- I HEREBY CERTIFY, That I attended deceased from 5-6- 1924 to 5-11- 1924

that I last saw h[illegible] alive on 5-11 1924

and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Chronic Myocarditis

Pulmonary Edema

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pyloric Ulcer

(Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/8/24

Was there an autopsy? No

What test confirmed diagnosis? Phys Sdys + Lab

(Signed) H. W. Harpel M. D

, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary Cemetery	May 14, 1924
20-UNDERTAKER,	ADDRESS
H. Sander Sons	1210 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-12-23-21-E.B.R.S.-400 Pks. Dr. Szczerbicki 735 S. Linwood ave.

D 86857

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86857

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 643 S. Linwood Ave. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Williams Talley

(a) Residence No. 643 S. Linwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Talley

6-DATE OF BIRTH (month, day and year) Feb. 22, 1860

7-AGE. 64 yrs. 2 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) Mrs. Williams Erlbeck

(Address) 643 S. Linwood Ave

15- Filed MAY 12 1924 192.... Robert F. ... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 9, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 20 19 24 to May 9 19 24

that I last saw him alive on May 9 19 24

and that death occurred, on the date stated above, at. 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. E. and Symp.

(Signed) H. Szczerbicki M. D

(Address) St. Joseph's Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Evangelical Cem.	May 13 1924
20-UNDERTAKER.	ADDRESS.
L. Sander Sons	1710 Pleet St

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86858

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86858

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 924 S. East ave ST., N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Lebompte

(a) RESIDENCE NO. 924 S. East ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Lebompte

6 DATE OF BIRTH (month, day, and year) March 20-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Acid Chamberman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Griffith + Boyd Co., 1861

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Lebompte

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Frances Lebompte

(Address) 924 S. East ave

15 FILED 2-1924, 19 Robert P. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 12, 1924, that I last saw him alive on May 11, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? observation

(Signed) Horace B. Tillotson, M. D.

, 19 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cem.	May 14 1924
20 UNDERTAKER	ADDRESS
Zrikler + Zrikler	1739 E. Eager St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

(Precise)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86859

CERTIFICATE OF DEATH.

16 X 49

D 86859

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Presis

(a) Residence No. Peace Ave. & Smith Point Road St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 16 1875

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland.

PARENTS.

10-NAME OF FATHER, Jos Presis

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland.

11- (Informant) Mrs. Mary Bzymanick

(Address) North Point Road and Wise Ave

15- Filed ..... 192..... Robert E. Mattick, Registrar.

Burial Permit Clerk.

MAY 12 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/11/24

17- I HEREBY CERTIFY, That I attended deceased from January 9 1924 to May 11 1924

that I last saw h/im alive on May 11 1924

and that death occurred, on the date stated above, at 6 – A m.

The CAUSE OF DEATH* was as follows:

Hamangio sarcoma of Iliac vessels - general metastases Cachexia

(Duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? U. H. Hospital

Did an operation precede death? Yes Date of 1/9 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological findings

(Signed) Wm. J. Fuller M. D.

, 19 . (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	May 13 1924
20-UNDERTAKER.	ADDRESS
John A Weber	1803 Bank

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 15 WARD)

2-FULL NAME Baby Wattington (Ruth)

(a) RESIDENCE No. 310 Walbrook ave ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11, 1924

7 AGE	Years	Months	Days	If LESS than 1 day 17 hrs 35 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Paul B Wattington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Grace E. Artis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Mrs. Paul B. Wattington
(Address) .....

15 MAY 12 1924 Filed ..... Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 5.00 P.M. May 11, 1924 to 10.35 A.M. May 12, 1924

that I last saw her alive on May 12, 1924

and that death occurred, on the date stated above, at 10.35 m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

17 hrs 35 min.
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Postmortem Spinal Puncture only.

What test confirmed diagnosis? Spinal Puncture.

(Signed) Thos A Tompkins M. D.

, 19 (Address) 11 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL May 13, 24

20 UNDERTAKER Bertram Gore

ADDRESS 1723 W Fay

Daniel Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86861

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 10T-00D 86861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hospital ST., 41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Branch

(a) RESIDENCE NO. 904 J St ST., Harrow Point WARD Sparrows Pt. Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 24 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	24	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor Bethlehem

(b) General nature of industry, business, or establishment in which employed (or employer) Steel Co Sparrow Pt

(c) Name of employer 046

9 BIRTHPLACE (city or town) (State or country) Gilmore Va

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bethlehem Steel Co

(Address) Sparrow Point Md

15 MAY 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5—9— 1924

17 I HEREBY CERTIFY, That I attended deceased from 5—7— ,1924, to 5—9— ,1924.

that I last saw him alive on 5—9— ,1924,

and that death occurred, on the date stated above, at 7 35 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

From history

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sparrows Pt. Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1726 N. Monut St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnson Va	May 12 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86862 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86862

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. 1186 Nanticoke St. 21 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Fischer

(a) Residence No. 1186 Nanticoke St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) E. Fischer

6-DATE OF BIRTH (month, day and year) Aug 12 1877

7-AGE 46 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) 603
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Germany

PARENTS:
10-NAME OF FATHER William Fischer
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) E. Fischer
(Address) 1186 Nanticoke

15- Filed MAY 21924 Robert P. Harris Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12-24

17- I HEREBY CERTIFY, That I attended deceased from May 6 19 24 to May 12 19 24 that I last saw him alive on May 12 19 24 and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Oedema Lungs

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Wm F. Schumann M. D.

19 (Address) 11 N Eden St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
London PK Cemetery	5-14-24
20-UNDERTAKER. Geo Lennbacher Son	ADDRESS 647 W Pratt St.

Burial Permit filed

MAY 1 21924

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86863

CERTIFICATE OF DEATH.

179

D 86863

1-PLACE OF DEATH

City of BALTIMORE (No. 728 N. Carrollton ave St. 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Alford

(a) Residence No. 728 N. Carrollton av St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Mitchell alfd

6-DATE OF BIRTH (month, day and year) May 20 1850

7-AGE. 73 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer). 871

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. James E Alford

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Mary Jane Edmondson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14-

(Informant) Mary V. Alford

(Address) 728 N. Carrollton ave

15-

MAY 1 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/11/24

17- I HEREBY CERTIFY, That I attended deceased from 5/6/24 19.. to 5/11/24 19..

that I last saw h— alive on 5/11/24 19..,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Brain of microscopic

(Signed) Jno C Fetterolf M. D.

5/12 1924 (Address) 2244 N Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. May 13, 1924

20-UNDERTAKER. John O. Mitchell

ADDRESS 2016 W Fayette St

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86864

CERTIFICATE OF DEATH.

100-00 ✓ D 86864

1-PLACE OF DEATH

City of BALTIMORE: (No. 2407 Elsinore Ave 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Craig Kelly.

(a) Residence No. 2407 Elsinore Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Bessie B. Kelly

6-DATE OF BIRTH (month, day and year) July 22 1843

7-AGE, 81 yrs. — mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Carlins Park

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), N. Y.

PARENTS.

10-NAME OF FATHER Nathaniel Kelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), N.Y.

12-MAIDEN NAME OF MOTHER Georgiana Staple

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Mrs Bessie B Kelly

(Address) 2407 Elsinore Ave

15-

Filed Robert P. Harrison, Registrar.

MAY 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 12-24

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 12 1924

that I last saw h— alive on May 11 1924

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 11 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) W B Nesbitt M. D.

May 12 19 (Address) 2220 Garrison

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem. DATE OF BURIAL, May 14, 1924

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86865

160 D 36865

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2015 E. Fairmount ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Mairelett

(a) RESIDENCE NO. 2015 Fairmount ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) April 4 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	8	

8 OCCUPATION OF DECEASED Infant

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Louis Mairelett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Annetta Secci

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Louis Mairelett

(Address) 2015 Fairmount Av

15 MAY 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to ....., 19....,

that I last saw her alive on May 11, 19 24;

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) several weeks.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Meyer Ephraim M. D.

, 19 (Address) 1906 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents — DATE OF BURIAL May 13 1924

20 UNDERTAKER Kendall Wyvell & Son — ADDRESS 398 N

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 12 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36866

CERTIFICATE OF DEATH.

D 36866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 25 WARD) from 1924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno E. Elgert

(a) RESIDENCE NO 7 W Biltmore ave ST., Violetville WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Md

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan - 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
68	~~12~~	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Elgert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Wm E Elgert
(Address) 9 Whitmore Ave

15 Dec 4 1924 Robert P. Harrigan, Registrar

MAY 12 1924

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

May 12 1924 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 5/13 1924

20 UNDERTAKER Wm J Tichnor & Son — ADDRESS North Ave

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Louis Adler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86867

CERTIFICATE OF DEATH.

91-002

D 86867

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1822 Prestman ST., 15 WARD)

2-FULL NAME Louis Aler

(a) RESIDENCE No. 1822 Prestman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Adler

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cattle Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Cattle

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Benj. Adler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bertha Adler

(Address) 1822 Prestman St

15 MAY 12 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1924

17 I HEREBY CERTIFY, That I attended deceased from May 9 1924 to May 11 1924

that I last saw h alive on May 11 1924

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Arteris-Sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. D. Hunt, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL May 13 1924

20 UNDERTAKER J. Ahern & Co ADDRESS 1601 Madison Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AY 12 1924

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86868

CERTIFICATE OF DEATH.

105 D 86868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Edmondson Ave ST., 16 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Seebo

(a) RESIDENCE NO. 1922 Edmondson Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry C. Seebo

6 DATE OF BIRTH (month, day, and year) Sept 29 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Son (Family)
(Address) 1922 Edmondson Ave.

15 Filed MAY 12 1924, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1922, to May 11th, 1924,

that I last saw her alive on May 11th, 1924,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) 1 yrs. 7 mos. 12 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical

(Signed) H. L. Seagrave, M. D.

May 12 1924 (Address) 1922 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 5-13 1924

20 UNDERTAKER: E & I Staub — ADDRESS: 1755 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86869

CERTIFICATE OF DEATH.

58

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1210 Homewood Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Aloysius Carroll Smith

(a) Residence No. 1210 Homewood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 4 ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Aug 5 - 1852

6-DATE OF BIRTH (month, day and year)

7-AGE. 71 yrs. 9 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Sugars

(b) General nature of Industry, business, or establishment in which employed (or employer). Broker

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Benj Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Elizabeth Neale

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant). Helen Smith

(Address). 1210 Homewood Ave

15- Filed ..., 192 ... Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 9-24

17- I HEREBY CERTIFY, That I attended deceased from Apr 22, 19.., to May 9, 1924, that I last saw h.. alive on May 9, 24 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Anaemia, pernicious

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Suppression of urine

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C H Hayward, M. D.

, 19 (Address) 2254 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cathedral	May 13, 1924
20-UNDERTAKER,	ADDRESS
J. C. Medfield 9	Fremont Ave

(1) WRITE PLAINLY, WITH UNFADING INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86870

CERTIFICATE OF DEATH.

D 86870

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robinson L. Williams

(a) RESIDENCE NO. 1329 N. Eutaw ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert William

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Farrar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 MAY 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 12, 1924,

that I last saw him alive on May 12, 1924,

and that death occurred, on the date stated above, at 3.40 m.

The CAUSE OF DEATH was as follows:

Primary Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R Bruce, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL May 14 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Mosher St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

86871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86871

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 645 Vine St., W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Woodous

(a) Residence No. 645 Vine St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 1862

7-AGE, 62 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Proprietor 86

(b) General nature of industry, business, or establishment in which employed (or employer) Stall in market

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Frank Woodous

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Martha Collers

(Address) 645 Vine St

15-

Filed ..... 192 ..... Registrar.

MAY 13 1924 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 9-1924

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1924, to May 9, 1924, that I last saw h alive on May 9, 1924, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Embolism

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Symptoms

(Signed) C. H. Finan, M. D.

(Address) May 12 1924 725 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL, May 13 1924

20-UNDERTAKER, John H. Toadvine — ADDRESS 1412 Druid Hill Ave

THIS CERTIFICATE BECOMES A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86872 ✓ 3 | D 86872

D 86872

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 27 S. Fulton Ave St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Beulah E. Delavoe

(a) Residence No. 27 S. Fulton Av St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 27, 1856

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... (State or Country), Eastern shore Md

PARENTS.

10-NAME OF FATHER, Wm Delavoe

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary A Musick

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Md

14- (Informant) Miss Margaret Murray

(Address) 27 S. Fulton Ave

15- Filed MAY 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 19 23 to March 19 24 that I last saw h[illegible] alive on March 29 1924 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

[redacted] (Duration)... yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary He[illegible]

(Duration)... yrs. mos. ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? [redacted] Date of...

Was there an autopsy? no

What test confirmed diagnosis? history of case

(Signed) Edwin K Ballard M. D

May 13 1924 (Address) 1622 Mt Royal Av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	May 16, 1924
20-UNDERTAKER, George J Smith	ADDRESS 1532 Hollins st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86873

CERTIFICATE OF DEATH.

118-002 D 86873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp't. ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mable Markland

(a) RESIDENCE NO. 3811 Asburton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Five yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Heckrotte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Thomas J Markland

(Address) ~~3811 Asburton Ave~~ 3811 Asburton Ave

15 MAY 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23-24 to May 11, 1924.

that I last saw h.er alive on May 11, 1924,

and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Hem Paralysis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5-7-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) Jno A Compton, M. D.

, 19 (Address) Md Gen Hosp Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 14 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86874

CERTIFICATE OF DEATH.

91-00 D 86874

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 337 Yale Ave. ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Fink.

(a) RESIDENCE. No. 128 S Vincent St. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Fink

(Address) 337 Yale Ave

Filed MAY 13 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 21st, 1924, to May 12, 1924, that I last saw him alive on May 11, 1924, and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Cerebro Hemorrhage.

.....(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) J. Stanfield Carr, M. D.

5/12/1924 (Address) 11 W Centre St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 16 1924
20 UNDERTAKER	ADDRESS
George J. Smith	Hollins

Spec.–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86875

CERTIFICATE OF DEATH.

88 ✓

D 86875

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2015 W. Lanvale St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Bayer

(a) Residence No. 2015 W. Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Bayer

6-DATE OF BIRTH (month, day and year) March 15 1836

7-AGE.	If LESS than 1 day,
88 yrs. 0 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer). None 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Buel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) William Bayer

(Address) 2015 W. Lanvale St

15- Filed MAY 31 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 10 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec, 1923, to May 10, 1924

that I last saw her alive on May 9, 1924

and that death occurred, on the date stated above, at 8 40 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5-11-24 (Address) 3 W. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	May 13, 1924
20-UNDERTAKER.	ADDRESS
Jos Jourdens & Son	2178 Pa. Ave

B.—NAME, NAME OF HUSBAND OR WIFE, AND RESIDENCE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86876

X74-007

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Northeastern of Notre Dame St. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Theodula Holzer

(a) RESIDENCE. No. Linguetta St & Roland Ave St., WARD. Phila Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 26 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 668

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburgh Pa
(State or country)

PARENTS

10 NAME OF FATHER Peter Holzer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Scheuer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sister Mary Dionysia
(Address) Notre Dame Linguetta St

15 MAY 13 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 12 - 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 12, 1924, that I last saw h alive on May 12, 1924, and that death occurred, on the date stated above, at 12-10 p.m.

The CAUSE OF DEATH* was as follows: I.L. Acute gastro intestinal toxemia uremia Edema is- Cerebral

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. F. Kelly, M. D.

5/12, 1924 (Address) No 110 E Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Notch Cliff Md	May 14 1924
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86877

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 86877

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Binney ST., 1 WARD)

2-FULL NAME Charles A. Timmerty.

(a) RESIDENCE NO. 1102 Binney ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	11	10	

8 OCCUPATION OF DECEASED Carpenter Helper

(a) Trade, profession or particular kind of work at Shedden Shop.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 015

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Timmerty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Cooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Margaret Timmerty

(Address) 1102 Binney St.

Filed MAY 13 1924 ROBERT R. KRAUTH Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to May 10, 1924, that I last saw him alive on April 14, 1924 and that death occurred, on the date stated above, at 11 p m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. H. Neer, M. D.

5/17/24 (Address) 408 S Patapsco Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 14th 1924
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4003 W. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86878

1-PLACE OF DEATH Univ. Hospital

CITY OF BALTIMORE: (No. ..... ST., W WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elbert H. Cooper

(a) RESIDENCE NO. Glen st Relay ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Jan 10 1908

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
16	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Owings Mills
(State or country) Md

PARENTS

10 NAME OF FATHER Elbert Cooper

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Co Md

12 MAIDEN NAME OF MOTHER Blanch Disney

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto Co Md

14 Informant Elbert Cooper
(Address) Relay Md

15 MAY 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13/24

17 I HEREBY CERTIFY, That I attended deceased from 5/7/24, 19 ..., to 5/13/24 19 ...,
that I last saw him alive on 5/13/24, 19 ...,
and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Empyema & Sphenoidal sinus.
Staph & Streptococcus.

..... (duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/10/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Wm Ashton Jones, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Hill Cemetery	May 13 1924
20 UNDERTAKER	ADDRESS
J. F. Ebaugh	Reisterstown Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86879

CERTIFICATE OF DEATH.

100 D 86879

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Furley Ave & Brehms Lane St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Engelhardt Hotter

(a) Residence No. Furley Ave & Brehms Lane St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Don't know

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired 86 20

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) John H. Kilian

(Address) Furley Ave & Brehms Lane

15- ROBERT R. KRAUTER, Registrar.

MAY 13 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/10/1924

17- I HEREBY CERTIFY, That I attended deceased from 5/9/24, 19.24, to 5/10, 19.24,

that I last saw h alive on 5/10, 19.24

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

This man was ill when seen by me would

Know a Suspicion (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Under 3/9/24

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) C. L. Cone M. D.

5/12, 1924 (Address) Gardenville

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	May 13, 1924
20-UNDERTAKER. John Ullrich	ADDRESS 2008 Aliceanna

R. S. 8—WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86880

HEALTH DEPARTMENT—CITY OF BALTIMORE. D 86880

CERTIFICATE OF DEATH.

188-04

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip J. Freund.

(a) RESIDENCE NO 112 E. Cross St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 8 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of Emma Freund.

6 DATE OF BIRTH (month, day, and year) September 5, 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	38	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakesman.
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Freund.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Genevieve Hilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Emma Freund. (wife)
(Address) 112 E. Cross St.

15 Filed MAY 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the hip.
Accidentally run over by a train
drawn by Engine No. 371, B. & O. R. R. Co.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

May 12th. 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.
Where was disease contracted, if not at place of death?
Accident Howard & Ostend Sts.
Date of accident, injury or last illness May 10, 1924.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	May 13 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86881

CERTIFICATE OF DEATH.

X 36-005 D 86881

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St. & Rutland Ave, WARD) 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Hoiberg.

(a) RESIDENCE NO. Washington, D. C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hebrew Hospital records (Address)

15 Filed MAY 13 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12/24 19

17

I HEREBY CERTIFY, That I attended deceased from 3/15, 19 24, to 5/12, 19 24.

that I last saw him alive on 5/12, 19 24,

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Undetermined.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/9/24

Was there an autopsy? Yes.

What test confirmed diagnosis? Laboratory examinations

(Signed) Isidor L. Frey, M. D.

May 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. DATE OF BURIAL May 13 1924

20 UNDERTAKER John Ulrich ADDRESS 2918 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86882

CERTIFICATE OF DEATH.

129 D 86882

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 522 S. 14th St. 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary S. Lynch

(a) Residence No. 522 S. 14th St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas W. Lynch

6-DATE OF BIRTH (month, day and year) Nov. 2, 1878

7-AGE. 45 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home 037

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. John Horney

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Susanna Bryan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Thomas W. Lynch

(Address) 522 S. 14th St.

MAY 13 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 4 1924 to May 11 1924

that I last saw her alive on May 10 1924

and that death occurred, on the date stated above, at 5 25 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) yrs. 1 mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Caleb N. Bikey M. D.

May 13 1924 (Address) 100 S. Potteran Pike or

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	May 15 1924
20-UNDERTAKER.	**ADDRESS**
W. Vanderwende Sons	1710 Fleet St

EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86883

CERTIFICATE OF DEATH.

90 D 86883

1-PLACE OF DEATH Hopewood Sportsmens REGISTERED NO.....

CITY OF BALTIMORE: (No Charles & 31 ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel H. Regester

(a) RESIDENCE No. Chas & 31 st ST., 12 WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella Graham

6 DATE OF BIRTH (month, day, and year) Mar 26, 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82.	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER J. Regester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hunterstown Pa

12 MAIDEN NAME OF MOTHER Eliz Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Jno H. R. Price
(Address) Hopewood & Sportsmens

15 MAY 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Arteriosclerosis
Heart
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison, M. D.
(Coroner.)
May 13, 1924 (Address) 1432 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	May 13 1924
20 UNDERTAKER Henry W. Thomas & Son	ADDRESS 805 N. Calvert St

Name should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 86884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 Baker St ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Glascol

(a) RESIDENCE. NO. 517 Baker St ST., WARD.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 - 1917

7 AGE 6 Years 10 Months 12 Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Bernard Glascol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Marion Conroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant Bernard Glascol
(Address) 517 Baker St

15 Filed . 19 ROBERT R. KRAUTER, Registrar
MAY 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11-1924

17 I HEREBY CERTIFY, That I attended deceased from 4-24-, 1924 to 5-11-, 1924 that I last saw him alive on 5/11/24, 19 , and that death occurred, on the date stated above, at 4:15P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) General debility due to abscess leg

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto md

Did an operation precede death? operation for abscess leg

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W H Hopkins M. D.

, 19 (Address) 1618 Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters cemetery

DATE OF BURIAL: May 13 1924

20 UNDERTAKER: Joseph A Farrell

ADDRESS 2311 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

14

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86885

CERTIFICATE OF DEATH.

111-001

111 D 86885

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 20 WARD)

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hetwig G.C. Wockenfuss

(a) RESIDENCE NO. 2227 Ashton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul F. Wockenfuss

6 DATE OF BIRTH (month, day, and year) July 21/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of Industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Julius ?. Winskoski

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Wanda I. Schultz

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Paul F. Wockenfuss
(Address) 2227 Ashton st.

15 MAY 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Peritonitis- Cardiac Failure

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Ruptured Gastric Ulcer (duration) yrs. mos.

(Signed) J S H Coleman, M. (Coroner.)

May 12/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs., mos., 12 ds. In the State 32 yrs., mos.,

Where was disease contracted, if not at place of death?

Former or usual residence 2227 Ashton St.

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ St Pauls. Violetville DATE OF BURIAL MAY 14

20 UNDERTAKER Geo N. Lattle ADDRESS 2700 Edmondson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 86886

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

D 86886

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 1329 Dargent ..... St. 21 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles E. Schumann

(Residence in Baltimore: No. 1329 Dargent ..... St. 49 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH

Dec (Month) 10 (Day), 1862 (Year)

7 AGE

61 yrs. 5 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Tobacco 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (State or country) Balto

PARENTS

10 NAME OF FATHER John Schumann

11 BIRTHPLACE OF FATHER (State or country) Germ

12 MAIDEN NAME OF MOTHER Elizabeth Zeller

13 BIRTHPLACE OF MOTHER (State or country) Germ

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Schumann

(Address) 1329 Dargent

15 Filed MAY 13 1924, 191 ROBERT R. KRAUTER, REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 11 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1920, to May 11 1924

that I saw h— alive on May 11, 1924

and that death occurred, on the date stated above, at 6 45 p. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Carcinoma of Prostate

..... (Duration) 3 yrs. 6 mos. ..... ds.

(Signed), W B Wolf M. D.

....., 191..... (Address) 113 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
London Park	May 14, 1924

20 UNDERTAKER,	ADDRESS
Geo J Fellis	1200 W Lemland

Spec.—1-10-21—M&T—1500 Bks.

D 86887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 D 86887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob I. Katz.

(a) RESIDENCE NO. 243 N. Patterson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Katz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer) Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Kulp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levy

(Address) 1439 E Balto St

15 Date received MAY 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1924, to May 12, 1924, that I last saw him alive on May 12, 1924, and that death occurred, on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH* was as follows:

Staphylococcus septicemia.

(duration) yrs. over 5 mos. ds.

CONTRIBUTORY (Secondary) (1) Carbuncle of temporal region (2) Diabetes Mellitus (duration) yrs. 2 mos. mos ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Cultures (2)

(Signed) A. Adler Stephenson, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 5/13 1924

20 UNDERTAKER Jack Levy

ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86888

CERTIFICATE OF DEATH.

100-001

D 86888

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S Broadway ST., 17 WARD)

2-FULL NAME Paul Pryor

(a) RESIDENCE NO. 110 S Broadway ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 7th '73

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	✓	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Crawford Pryor

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Utley

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Howard Robins
(Address) 110 S Broadway

15 Filed MAY 1 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from May 7th, 1924, to May 11th, 1924

that I last saw h[illegible] alive on May 10th, 1924

and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (duration) yrs. ..... mos. 5 ds.

CONTRIBUTORY ✓
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

19 (Address) 824 Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL May 13 1924

20 UNDERTAKER Samuel Pewsley

ADDRESS 1148 N Bradford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86889

CERTIFICATE OF DEATH.

44 D 86889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 N. Howard ST.; 11 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie C. Willis

(Residence in Baltimore: No. 939 N Howard St.; 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Oct 11, 1879
(Month) (Day) (Year)

7-AGE, 49 yrs. ..... mos. 19 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, Richard R Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Martha Blake

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Snyder

(Address) 939 N. Howard St.

15-

Filed ..... 191.....

MAY 13 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 10th, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 4/20 1924, to 5/10 1924

that I saw h-e alive on 5/9 1924,

and that death occurred, on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

Stomach

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B. M. Klotz M. D.

5/13, 1924 (Address) 2135 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Md — DATE OF BURIAL, May 13, 1924

20-UNDERTAKER Samuel J Kirby — ADDRESS 1 E Biddle St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 16-0-19—H. P. C. 1000 Bks.

D 86890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001 D 86890

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1416 E. Preston ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertie M. Stine

(a) RESIDENCE. No 1416 E. Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of George T. Stine

6 DATE OF BIRTH (month, day, and year) March 28-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Stafford Co Va

PARENTS

10 NAME OF FATHER Thomas Shilditch

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emily Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant George T. Stine

(Address) 1416 E. Preston St

MAY 13 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 11 - 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 11, 1924, that I last saw her alive on May 10, 1924, and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. L. Bonsteen, M. D.

5/12, 1924 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 14 1924

20 UNDERTAKER Henry Lutz ADDRESS 203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 8689[illegible]

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D 86891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1737 Pataps co St. St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Wendel

(a) Residence No. 1737 Pataps co St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 23 1923

7-AGE.	If LESS than 1 day.
yrs. 11 mos. 19 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Md. (State or Country).

PARENTS.

10-NAME OF FATHER, George Wendel

11-BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or Country).

12-MAIDEN NAME OF MOTHER, Viola Squires

13-BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or Country).

14- (Informant) George Wendel

(Address) 1737 Patapsco

15- Filed MAY 13 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12, 1924.

17- I HEREBY CERTIFY, That I attended deceased from April 20 1924 to May 12 1924 that I last saw her alive on May 4 1924 and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Faulkner M.D. M. D.

May 13. 1924 (Address) 1E Randall St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cemetery	5/14 1924
20-UNDERTAKER.	**ADDRESS**
J. Fred McCully	130 S. Front

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86892

CERTIFICATE OF DEATH.

D 86892

139

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument & N. Rathmuhl St. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Millie Heyman

(a) RESIDENCE NO. 910 S. Charles St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? 33 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Heyman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Bloom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Heyman (Address) 910 S Charles St

15 Filed MAY 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1924 to May 12, 1924.

that I last saw her alive on May 12th, 1924

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows: Postoperative Shock

shock

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Fibroid Tumor Uterus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/12/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H Adler Goodheimer M. D.

5/12, 1924 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Rd	5/13 1924
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Ryjwick ✓

D 86893 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86893

+ 12

CERTIFICATE OF DEATH. REGISTERED NO.

1-PLACE OF DEATH U. S. Marine Hospital #1 Baltimore Md

CITY OF BALTIMORE: (No. U.S.M.H. #1, ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Rygrits.

(a) RESIDENCE NO. U.S. Marine Hospital #1 ST., WARD

(Usual place of abode) Baltimore Md (If non-resident give city or town and State)

Length of residence in city or town where death occurred ——yrs. ——mos. ds. How long in U. S., if of foreign birth? ——yrs. ——mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 11, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman O.S.

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S/S Robin Gray

9 BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Norway (State or country)

14 Informant ... (Address) Dead

MAY 13 1924 HUBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 - 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to May 11, 1924, that I last saw him alive on May 11, 1924, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Fatty and Disease of Heart, Chronic Lesion, Aortic & Mitral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Paracholysis

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? On Board

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) M. V. Foster. M. D.

5/12, 1924 (Address) U. S. Marine Hospital #1 Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL 5/13 1924

20 UNDERTAKER Sol Levinson Bro — ADDRESS 422 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 86894

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 N. Bond, ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Davis

(a) RESIDENCE No. 403 N. Bond, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Portland.

PARENTS

10 NAME OF FATHER Samuel Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala.

12 MAIDEN NAME OF MOTHER Daisy Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daisy Bryan (Address) 403 N. Bond St.

15 Filed MAY 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12-1924

17 I HEREBY CERTIFY, That I attended deceased from 5-8-1924, to 5-12-1924, that I last saw h alive on 5-10-1924, and that death occurred, on the date stated above, at 12,10 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

5-12 1924 (Address) 611-N-Conn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 14 1924
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	416 N. Carolina St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86895

CERTIFICATE OF DEATH.

129 D 86895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 512 (ST.) Park ave (WARD) 11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilie McKim Reed

(a) RESIDENCE NO. 512 (ST.) Park ave (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow of Wm Reed

6 DATE OF BIRTH (month, day, and year): May 10 1840

7 AGE: Years 84. Months Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Edward Telfair McKim

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza Beatty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Telfair McKim Marriott 113 St Paul

15 Filed MAY 13 1924 HUBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10th 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 26th, 1924, to May 10th, 1924, that I last saw her alive on May 10th, 1924, and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis of at least 6 weeks duration.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Uterine Fibroid

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eleanor C. Price M. D.

, 19 (Address) 1710 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: May 13th 1924

20 UNDERTAKER: Henry A Jenkins Sons Co

ADDRESS: McCulloh & Oliver Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86896

CERTIFICATE OF DEATH.

D 86896

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Walker

(a) Residence No. 721 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 18—?

7-AGE	If LESS than 1 day,
60-70 ? yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9-BIRTHPLACE (city or town) ? (State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAY 13 1924 Registrar.

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-10-24

17- I HEREBY CERTIFY, That I attended deceased from 5-9, 1924 to 5-10, 1924

that I last saw h.. alive on 5-10, 1924

and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Dorsey M. D.

5-12, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Glenwood Cemetery	5/13/24
UNDERTAKER,	ADDRESS
P. C. Gross	1405 McElderry

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 86897 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 86897

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 527 W Volvo ST.: W 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Milburn

(a) RESIDENCE. No. 527 W Volvo ST., 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Milburn

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 0 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs R. A. Elliott 1225 Ashland Ave

15 Filed . 19 HUBERT R. KRAUTER, Registrar

MAY 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1924, to May 10, 1924

that I last saw him alive on May 10, 1924

and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. B. Hughes, M. D.

(Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Run Cemetery	May 13 1924
20 UNDERTAKER	ADDRESS
Mrs R. A. Elliott	1225 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86898 ✓ D 86898

D 86898 CERTIFICATE OF DEATH. 93

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Adams

(a) Residence No. 637 W. Fayette St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Accountant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Chicago.

(State or Country). Illinois

PARENTS.

10-NAME OF FATHER, Ben Adams

11-BIRTHPLACE OF FATHER (city or town). Boston

(State or Country), Mass.

12-MAIDEN NAME OF MOTHER, Agnes Adams

13-BIRTHPLACE OF MOTHER (city or town). Braine,

(State or Country), Mass.

14-

(Informant).....

(Address). UNIVERSITY OF MARYLAND

Filed MAY 13 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/10/24

17- I HEREBY CERTIFY, That I attended deceased from March 11, 1924, to May 10, 1924,

that I last saw him alive on May 10, 1924,

and that death occurred, on the date stated above, at 12-5 A. m.

The CAUSE OF DEATH* was as follows:

Peripheral Neuritis.

(Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of March 20 '24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. H. Fuller M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ... 19....

20-UNDERTAKER, ADDRESS MAY 13 1924

Commissioner of Health.

N. B.—WHITE PAPER, WITH ONE CARBON LINE, THIS FORM IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland Genl Hospt. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Cohen

(a) RESIDENCE No. 129 North Pine ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Samuel Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Shutzky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1439 E. Balto. St.

15 Filed MAY 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13-24

17 I HEREBY CERTIFY, That I attended deceased from 4-2-24, 19..., to 5-13-24, 19..., that I last saw h[illegible] alive on 5-13-24, 19..., and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) ..... yrs. ..... mos 7 0 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 5-10-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Autopsy findings

(Signed) J. McFarland Hoyt, M.D.

..... 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon, May 13 1924 — DATE OF BURIAL

20 UNDERTAKER Jack Lewis, 1439 E. Balto. — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D 86900 -26

71-001 ✓ D 86900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., Y WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Dembucki

(a) RESIDENCE No. 417 S. Durham St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Dembucki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lina Bowiske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant JOHNS HOPKINS HOSPITAL (Address) Baltimore

15 Filed MAY 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1924

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to May 13, 1924,

that I last saw him alive on May 13, 1924,

and that death occurred, on the date stated above, at 1 20 A. m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Pneumococcus Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 417 S Durham St

Did an operation precede death? Yes Date of 5/7/24

Was there an autopsy? No

What test confirmed diagnosis? Operation Lumbar Puncture

(Signed) Thos. H. Cornell, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loft Rosary. DATE OF BURIAL May 14 1924

20 UNDERTAKER John M Weber ADDRESS 1803 Bond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86901

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86901

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Eastern Avenue & 3rd ST., 26 WARD)

2-FULL NAME Adam . Parzynski

(a) RESIDENCE No Trappe Road ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frances Parzynski

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mr John. Kowalski
(Address) Trappe Road

15 Filed MAY 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneum

(duration) yrs. mos. ds.

(Signed) Jos. C. Blades, M. D.
(Coroner.)
5/12/24 192 (Address) 143 N. 3 ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL May 14 1924

20 UNDERTAKER John M. Weber — ADDRESS 1803 Eastern Ave

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86902

CERTIFICATE OF DEATH.

D 86902

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST., 25 WARD)

2-FULL NAME Geraldine Forbes

(a) RESIDENCE NO. 86 Warner St Mpt ~~Station~~ WARD Wmans. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 25, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Forbes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 MAY 13 1924 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to May 12, 1924, that I last saw h~~e~~r alive on May 12, 1924, and that death occurred, on the date stated above, at 6 30 ~~P~~ m.

The CAUSE OF DEATH* was as follows Acute Secondary Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo. R. Bragg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville DATE OF BURIAL May 13 1924

20 UNDERTAKER Samuel Kemsley ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be filled in ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 Register St Court St., 6 Ward)

Registered No. 10 1 ✓

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Hickman

(a) Residence No. 1733 Register St Court St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie J Hickman

6-DATE OF BIRTH (month, day and year) 1869

7-AGE,	If LESS than 1 day,
55 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Ditch Digging

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Richmond Va

PARENTS.

10-NAME OF FATHER, John Hickman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Marguirite Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Annie J Hickman

(Address) 1733 Register St Court

15- Filed 192 Registrar.

MAY 13 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 12 - 24

17- I HEREBY CERTIFY, That I attended deceased from May 11, 1924 to May 12 1924

that I last saw h. alive on May 12 1924

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W Clyde Pennington, M. D.

5-13-24 (Address) 2017 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Woodberry Cemetery	May 14, 1924
20-UNDERTAKER,	ADDRESS 1631
Edward Bryan	Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86904

D 86904

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520 Liberty Heights St. (Ward) 48

2-FULL NAME Edward Walter Ennis

(a) RESIDENCE. No. 520 Liberty Heights Ave WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
WIFE of Mildred James

6 DATE OF BIRTH (month, day, and year) June 5th 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	3	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer) Commercial
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos W. James
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md
12 MAIDEN NAME OF MOTHER Gertrude Ballard
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Thomas W. James
(Address) 502 E Biddle St

15 Filed MAY 13 1924 19
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1924, to the May 11th, 1924, that I last saw h alive on May 11th, 1924, and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia as Acute
Broncho (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Wm H Thurman, M. D.

5/12 1924 (Address) 1701 N Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 14 1924
20 UNDERTAKER	ADDRESS
E A Niedfeld Jr	501 E 22 St

MAY 13 1924

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86905

CERTIFICATE OF DEATH.

10 1901 D 86905

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 W. Lexington St., 9 WARD)

2-FULL NAME Bernard A. Kilduff

(a) RESIDENCE NO. 611 W. Lexington St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year) January 17 - 21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Kilduff

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Ellen Shanahan

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country)

14 Informant (Address) John Kilduff 611 W. Lexington St

15 Filed MAY 13 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30 1924 to May 12 1924.

that I last saw h[illegible] alive on May 12 1924, and that death occurred, on the date stated above, at 12-05 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchitis.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

May 12, 1924 (Address) 401 E. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	May 14 1924
20 UNDERTAKER	ADDRESS
E. A. Wiedefeldt	502 E. 25th St

IN B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

D 86906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86906

CERTIFICATE OF DEATH.

3V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 N Charles ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Virginia Clark

(Residence in Baltimore: No. 1815 N Chas St. St.; 27 yrs., 0 mos. 18 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Single

6-DATE OF BIRTH, April (Month) 23 (Day), 1897 (Year)

7-AGE, 27 yrs. 0 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, James Wm Clark

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Jane S Kellam

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jane S. Clark (mother)

(Address) 1815 N. Charles St.

15-

Filed ..... Robert P. Harrison, 191...

Registrar.

MAY 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 11 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febr 1924, to May 1924, that I saw h 2r alive on May 11 1924, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Laryngeal

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion Anemia

(Duration) yrs. mos. 15 ds.

(Signed) Jos. S. L. Gretsinger M. D.

May 11 1924 (Address) 1516 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemy

DATE OF BURIAL, May 14 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 86907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+196

D 86907

1-PLACE OF DEATH Pronounced dead at

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. Jones

(a) RESIDENCE NO. Rennert Hotel ST., WARD Kyleville Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 20, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rodman
(b) General nature of industry, business, or establishment in which employed (or employer) Penna. Water &
(c) Name of employer Power Co.

9 BIRTHPLACE (city or town) (State or country) York Co. Pa

PARENTS

10 NAME OF FATHER Harry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lebanon Co Pa.

12 MAIDEN NAME OF MOTHER Hanit Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Co Pa

14 Informant Sewart Mowen Co.
(Address) 108 W. NorthAve

15 Dec 192 Robert P. Harrison, Registrar

MAY 13 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental - Electrocution
(While taking Elevations on feed wires)
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Kolb, M. D.
(Coroner.)

May 13/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 4 ds.

Where was disease contracted, if not at place of death? Orangeville - Balto Md

Former or usual residence Kyleville - Md

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kyleville - Pa. DATE OF BURIAL May 13 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(John Grogham)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86908

100-001

D 86908

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. John Grogham

(a) RESIDENCE NO. 1026 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Grogham

6 DATE OF BIRTH (month, day, and year): 1866 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Grogham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Beatrice?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records

(Address)

15 Filed . 19 Robert E. Matthews, Registrar

MAY 13 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12/1924

17 I HEREBY CERTIFY, That I attended deceased from 4/30/24, 19 to 5/12/24, 19

that I last saw h alive on 5/12/24, 19

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. V. Gilley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	May 15 1924
20 UNDERTAKER Robert E. Curran & Son, Per J. F. Curran.	ADDRESS 902 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

(John Toner)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86909

D 86909

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Toner

(a) Residence No. 903 Valley St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	W

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11-Informant Municipal Hospital Records

(Address)

15-Filed Reban F. Harrison, Registrar.

MAY 1 1924

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-11-24

17- I HEREBY CERTIFY, That I attended deceased from 5-6, 1924 to 5-11, 1924

that I last saw him alive on 5-11, 1924

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Acute Alcoholism

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub

(Signed) Claude T. Grace M. D.

5-12-1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Baltimore Cem	5-14, 1924
20-UNDERTAKER, H. C. Weidefeld	ADDRESS

WHITE PEARL, WITH ONE RING AND THREE LINES. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100-Bks.

(Patrick McGuire)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86910

202 D 86910

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) Mercy Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick McGuire

(a) RESIDENCE 1064 Forest. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Farston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John F McGuire (Address) 1064 Forest St

Filed MAY 13 1924, 192 Robert P. Harrigan, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 192 24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. 1 ds.

(Signed) Jos C. Blades, M. D.

(Coroner.)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkside Cemetery Pikesville Md.

DATE OF BURIAL May 14 1924

20 UNDERTAKER N. C. Wiedefeld 914

ADDRESS Grumert Bro

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1 10 21 MAY 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86911

CERTIFICATE OF DEATH.

1294 D 86911

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 29 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence E Burgan

(a) RESIDENCE No. 21 E. Hamilton ave. ST., Rockeburg WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lily R. Burgan

6 DATE OF BIRTH (month, day, and year) Sept 24th 1869

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
54	7	18	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer) Dairy

(c) Name of employer White Bros.

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas L. Burgan

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Sindall

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Lily R. Burgan
(Address) 21 E. Hamilton Ave. Rockeburg

15 Filed MAY 1 3 1924 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/9/24, 19..., to 5/12/24, 19...,
that I last saw h.. alive on 5/12/24, 19...,
and that death occurred, on the date stated above, at 6 H m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
Chronic Vascular Hypertension

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Winston Jr, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 14 1924
20 UNDERTAKER	ADDRESS
Fredk Lazarus Jr Sons	Fulleston

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 86912

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-083 D 86912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lexington St. Carrollton Ave. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Duggan

(a) RESIDENCE No. 1121 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 27th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Timothy H. Duggan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Marie J. Duggan
(Address) 1121 W. Franklin st

15 Filed MAY 13 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

at once (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by yellow Ford

(Duration) mos. ds.

(Signed) Thos. B. Horton, M. D. (Coroner.)

May 13th, 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dist. Mayo Govans	May 14 1924
20 UNDERTAKER	ADDRESS
C. C. Branning & Son	517 N. Schroeder

MAY 13 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should know that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward) 71-001

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Birkenshaw

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tobacco 0440

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Boston, Mass.
(State or Country),

PARENTS.

10-NAME OF FATHER, J. Birkenshaw

11-BIRTHPLACE OF FATHER (city or town). Boston
(State or Country), Mass

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). Boston,
(State or Country), Mass

14- (Informant) Municipal Hospital Record

(Address)

15- Filed MAY 13 1924 19?? Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-11-24

17- I HEREBY CERTIFY, That I attended deceased from 5-5, 19.24 to 5-11, 19.24

that I last saw him alive on 5-10, 19.24

and that death occurred, on the date stated above, at 5-XS 6 m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Septicemia

Pneumococcus Meningitis

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab & Autopsy

(Signed) Claude 9 Drace M. D.

5-12. 19 24 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 14, 19 24
20-UNDERTAKER. Mr. & Mrs. John W. Geupel & Son	ADDRESS 801 W. Fayette

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 13 1924

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86914

CERTIFICATE OF DEATH.

90 D 86914

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 4407 Penhurst Ave ST., 28 WARD)

2-FULL NAME William N. Stewart

(a) RESIDENCE NO. 4407 Penhurst Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk Druggist 09
(b) General nature of industry, business, or establishment in which employed (or employer) Retail Drug store
(c) Name of employer Buchman & Bowden Balto Md

9 BIRTHPLACE (city or town) ..... (State or country) Balto Md

PARENTS

10 NAME OF FATHER James F. Stewart

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Louie V. Schauer

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant J. Marshall Stewart (Address) 4108 Penhurst Ave

15 Filed MAY 13 1924 By Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Hemmeter, M. D.
(Coroner)
May 12, 1924 (Address) 280 Redwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL May 14 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

MAY 13 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be answered for-mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86915 X 117 D 86915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys Lancaster

(a) RESIDENCE NO. Fallston ST., Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Three Yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harford Co, Md

PARENTS

10 NAME OF FATHER William Lancaster

11 BIRTHPLACE OF FATHER (city or town) Harford Co (State or country) Md

12 MAIDEN NAME OF MOTHER Bessie E. Rae

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Maryland

14 Informant W. J. Tichenor & Sons (Address) North & Penna. Ave.

15 Filed ....., 19.... Robert P. Harrison, Registrar

Burial Permit Clerk

MAY 13 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1924, to May 13, 1924

that I last saw her alive on May 13, 1924,

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5-13-24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) AC Mommsen M. D.

5-13-1924 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fallston Md.	5/14 1924
20 UNDERTAKER	ADDRESS
W. J. Tichenor Sons	North & Pennsylvania

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Knell, Augusta and Frederick

D 86916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86916

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 4112 Walrad Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Haffer

(a) Residence No. 4112 Walrad Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Haffer

6-DATE OF BIRTH (month, day and year) Feb 14 1835

7-AGE. 89 yrs. 2 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER John Schlening

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany.

14- (Informant) Henry Baker

(Address) 4112 Walrad Ave

15- Filed 19 Registrar.

Robert P. Harrison,

Burial Permit filed

MAY 13 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1 19 24 to May 12 19 24

that I last saw h.. alive on May 12 19 24

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

2

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Wm. A. Knell, M. D.

5/13, 19 24 (Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL, May 14 19 24

20-UNDERTAKER. Wm. Cook

ADDRESS 502 E Lafayette

PERMANENT RECORD. Every item of the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

at Dorsey, 1129 St Paul St

D 86917

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 43 East Hamilton Ave St. 27 Ward)

Registered No. 58-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bertha Filling

(a) Residence No. 43 East Hamilton Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 12. 1862

7-AGE, 61 yrs. 8 mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER. John Filling

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Eliza Schmidt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Anna G. Freburger

(Address). 4610 Springdale Ave

15- Filed MAY 13 1924, 192 Robert P. Harrison, Registrar.

Burial Permit clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12 1924

17- I HEREBY CERTIFY, That I attended deceased from APRIL 6, 19 24, to MAY 12, 19 24, that I last saw h. ER alive on MAY 12, 19 24, and that death occurred, on the date stated above, at 3 PM

The CAUSE OF DEATH* was as follows:

PERNICIOUS ANEMIA

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) John L. Dorsey, M. D.

, 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery DATE OF BURIAL, ..., 19....

20-UNDERTAKER. William Cook ADDRESS 502 E Nor

MAY 13 1924

Registrar.

Burial Permit clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 36918

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86918

CERTIFICATE OF DEATH.

188-083

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maribel Ann Algie

(a) RESIDENCE NO. 135 Rochelle Place ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER David Algie

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Sarah Hill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Grace Algie
(Address) 135 Rochelle Place

15 Filed MAY 1 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto Acc.
Fracture of Skull.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo Edward Bladel, M. D.
(Coroner)
5/12/24, 192 (Address) 143 N Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL May 5 192 4

20 UNDERTAKER H. M. Cook ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86919

CERTIFICATE OF DEATH.

x 144 36919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice R. Thomas

(a) RESIDENCE No. #24 Admiral Blvd ST. Dundalk Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Garfield Thomas

6 DATE OF BIRTH (month, day, and year) July 6 183

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	40	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Casey Ridge (State or country) Penna

PARENTS

10 NAME OF FATHER Francis A. Shivers

11 BIRTHPLACE OF FATHER (city or town) Scranton (State or country) Penna

12 MAIDEN NAME OF MOTHER Augusta Temble

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Fred Thomas (Address) 24 Admiral Boulevard

15 FILED MAY 13 1924 19 Robert P. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 10, 1924, that I last saw h. alive on May 10, 1924 and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage (Uterine).

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Placenta Praevia.

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John V. Pszelicki M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 14th 1924

20 UNDERTAKER H. C. Brauning & E. A. Brauning ADDRESS 517 N. Schroeder St.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86920

CERTIFICATE OF DEATH.

129 D 86920

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2206 Riggs Ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry A. Garhart

(a) Residence No. 2206 Riggs Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Garhart

6-DATE OF BIRTH (month, day and year) 1844

7-AGE. 80 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer). 86

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Henry Garhart

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country),

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) unknown
(State or Country),

11-

(Informant) Mrs. Garhart

(Address) 1603 Lafayette

15-

Filed MAY 1 1924 Robert P. Harrison, Registrar.

Burial Forest Glen.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 12-24

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 12 1924

that I last saw h— alive on May 11 1924

and that death occurred, on the date stated above, at 7A. m.

The CAUSE OF DEATH* was as follows:

1 Chronic Enteritis

Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. C. Buell M. D

5/14 1924 (Address) Irvington

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Friendship Hd	May 14 1924

20-UNDERTAKER Geo. J. Kuhn & Son ADDRESS 1735 Eastfordave

WHITE PAPER, WITH ONE SIDE UNRULED. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86921

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

2-FULL NAME Mary E. Cassiday (or Cancratius)

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1877 (?)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	48	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 665

(b) General nature of industry, business, or establishment in which employed (or employer) Religious work-

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Mathew Cassiday

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Irvine

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland-

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MAY 13 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec 18th, 1911, to May 13th, 1924,

that I last saw her alive on May 12, 1924,

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Pul. Tuberculosis -

abt 10 or 12 years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Duod. Ulcer. Psychosis

abt (duration) 14 or 15 years mos. ds.

18 Where was disease contracted if not at place of death? New Jersey -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 13, 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jersey City N.J.	May 14 1924
20 UNDERTAKER Stewart F Mercer Co	ADDRESS 1080 W. North Ave

(See Letter on file 6-31-24)

Spec.—1-10-21—M&T—1500 Bks.

D 86922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86922

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 E. Fort Ave ST., 24 WARD)

2-FULL NAME Domenico ~~Santo~~ Barranco

(a) RESIDENCE NO. 502 E. Fort Ave ST. 24 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucia Barranco

6 DATE OF BIRTH (month, day, and year) Feb 10 1870

7 AGE Years 54 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 034

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Dominic Barranco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosalia Sirna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant ..... (Address) 502 E. Fort Ave

15 Filed MAY 13 1924 19 Robert F. Carrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1924, to May 11, 1924, that I last saw him alive on May 10th 1924, and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

Arteriosclerosis (duration) ? yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Graham, M. D.

5/13, 1924 (Address) 627 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL 5/14 1924

20 UNDERTAKER P. Mangione

ADDRESS 1318 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86923

CERTIFICATE OF DEATH.

51 N 86923

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Battery Ave ST. [illegible] WARD) 24th

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Josephine Catherine Hannon

(a) RESIDENCE. NO. 1131 Battery Ave ST., 24th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millinery 69

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Snellenberg's Ollesides & Hiquith Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry J. Hannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fluvana, Virginia

12 MAIDEN NAME OF MOTHER Annie T. Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Trenton New Jersey

14 Informant Mrs. Annie T. Hannon

(Address) 1131 Battery Ave.

15 Filed MAY 13 1924

Robert P. Hartlieb, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from February 14, 1924, to May 11, 1924, that I last saw her alive on May 11, 1924, and that death occurred, on the date stated above, at 5 17 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1273 William St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	5/15 1924
20 UNDERTAKER	ADDRESS
F. J. Tetley & Sons	31 Eighth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 13 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86924

CERTIFICATE OF DEATH.

90 D 86924

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 24 WARD)

2-FULL NAME Henry C. Gooding

(a) RESIDENCE NO. 402 Sanders ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Gooding

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records
(Address)

15 Filed MAY 31 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-21, 1923, to 5-12, 1924

that I last saw h~~im~~ alive on 5-11, 1924

and that death occurred, on the date stated above, at 5-15 9 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic myocarditis; auricular fibrillation; myocardial insufficiency (duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) ½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub.

(Signed) Claude S. Knox, M. D.

5-12 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	May 14 1924
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86925

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 Wash. Boulevd ST.: 21 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Virginia Mason

(a) RESIDENCE. No. 816 Wash. Boulevd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm A. Mason

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wesley Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ann V. Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Florence M. Mason

(Address) 816 Wash Boulevard

MAY 13 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, (to May 12, 1924, that I last saw h-r alive on May 10, 1924, and that death occurred, on the date stated above, at 2 30 p m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What (est confirmed diagnosis? Clinical

(Signed) R Morley Strong, M. D.

May 13 1924 (Address) 729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	May 15 1924
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86926

CERTIFICATE OF DEATH.

1133

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5 W. Montgomery St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Hancock

(a) Residence No. 5 W. Montgomery St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	~~X~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 11-24

7-AGE.	If LESS than 1 day,
....yrs. 11 mos. 2 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John W. Hancock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, May Stewart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) John W. Hancock

(Address) 5 W. Montgomery

15-

Filed MAY 13 1924 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 13/24

17- I HEREBY CERTIFY, That I attended deceased from May 9 1924 to May 13 1924 that I last saw h[illegible] alive on May 13 1924 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro. Enteritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell M. D.

May 13, 1924 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn	May 14, 1924

20-UNDERTAKER.	ADDRESS
F. A. Krause & Son	703 Hanover

MAY 13 1924

WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86927

CERTIFICATE OF DEATH.

101-00

D 86927

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 637 Dolphin ST., 17 WARD)

2-FULL NAME Williams H. Farrell

(a) RESIDENCE NO. 637 Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Farrell

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) .....

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Catharine Frazier

(Address) 637 Dolphin St.

MAY 14 1924

Filed HUBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to May 11, 1924,

that I last saw him alive on May 10, 1924,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms

(Signed) H. X. Stemmler, M. D.

May 13, 1924 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	May 13 1924
20 UNDERTAKER	ADDRESS
Wm. H. Greer & Son	1700 Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86928

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86928

CERTIFICATE OF DEATH.

X 84

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 John ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Middleton Read

(a) RESIDENCE ~~No.~~ Yemassee South Carolina
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Six mos. 2 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Glover Read

6 DATE OF BIRTH (month, day, and year) November 20 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Planter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S. C.

PARENTS

10 NAME OF FATHER Benjamin Huger Read

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgetown S. C.

12 MAIDEN NAME OF MOTHER Mary Julia Middleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charleston S. C.

14 Informant Benjamin Huger Read (Address) 10 Maryland Trust Bldg.

15 Filed MAY 14 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from MARCH 20, 1924, to MAY 13, 1924, that I last saw him alive on MAY 13, 1924, and that death occurred, on the date stated above, at 11.00 A m.

The CAUSE OF DEATH* was as follows:

ANGINA PECTORIS

(duration) 10 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Dorsey, M. D.

(Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Yemassee S. C.

DATE OF BURIAL 5-14 1924

UNDERTAKER Henry W. Jenkins Son Co

ADDRESS Owners Mc Cullough

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86929 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86929

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Geneva Apt 3405 Greenway ST., 7 WARD)

2-FULL NAME Lenord M Levering

(a) RESIDENCE NO. Geneva Apt 3405 Greenway ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of Ella B Levering

6 DATE OF BIRTH (month, day, and year) Oct 23rd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariland.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene Levering

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann S Walker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Ella B Levering (Address) 3405 Greenway

15 Filed MAY 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to May 13, 1924.

that I last saw him alive on May 13, 1924

and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of the prostate.

(duration) 3 yrs. ± mos ds.

CONTRIBUTORY (Secondary) Pyonephrosis

(duration) - yrs. 1 mos. ± ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Cystoscope.

(Signed) Alan C Sutton, M. D.

5/13, 1924 (Address) 1107 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fellowmount Cemetery	May 15 1924
20 UNDERTAKER	ADDRESS
H H Jenkins Sons Co	Orchard & Gallows Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86930 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86930

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1844 W Pratt. (St.) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy P. Miller

(a) RESIDENCE. No. 1844 W. Pratt. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 15-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary J Calt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) John H. Miller 1844 W Pratt St

15 Filed MAY 14 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 12, 1924, that I last saw him alive on May 12, 1924 and that death occurred, on the date stated above, at 2.55 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) over

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Estelle Hemming M. D.

5/14, 1924 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 14 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	1401 Eutaw,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86931

101-001

D 86931

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3075 Vincent ST., 19 WARD)

2-FULL NAME Mamie allen

(a) RESIDENCE NO. 3075 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 13th 1917

7 AGE 6 Years 9 Months 29/6 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER James allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Flosie Laughley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant James allen (Address) 307 S. Vincent st

15 Filed ....., 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MAY 14 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-9-24, 19..., to 5-12-, 19 24

that I last saw h... alive on ", 19...

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows: Acute Lobar Pneumonia

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary) exposure

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. E. Landers, M. D.

, 19 (Address) 152 Gittell ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL May 14th Cofield N. C.

DATE OF BURIAL May 14th 1924

20 UNDERTAKER A. Jones

ADDRESS 111 S. Gilmor st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. PHYSICIANS should state AGE should be stated EXACTLY. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86932

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 86932

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Harford ave ST., 9 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph - a Ard.

(a) RESIDENCE NO. 1833 Harford ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word)
Male	White	Widowed

5a (If married, widowed, or divorced) HUSBAND of (or) WIFE of Lake Fannie Ard.

6 DATE OF BIRTH (month, day, and year) July 10-1852

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	71	10	1	~~If LESS than~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Plumbing

(c) Name of employer Effly Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph A. Ard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Fannie Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant George E. Ard
(Address) 1833 Harford ave.

15 Filed MAY 14 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/24. 19

17

I HEREBY CERTIFY, That I attended deceased from May 29, 19 23, to May 11, 19 24.

that I last saw him alive on May 11, 19 24

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder
over

(duration) yrs. 5 mos 11 ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John W Anderson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemtery.

DATE OF BURIAL 5/14/ 1924

20 UNDERTAKER Geo. J. Ruth

ADDRESS 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 86933

CERTIFICATE OF DEATH.

1917

REGISTERED No. C D 86933

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 13 WARD)

2-FULL NAME Robert Smith

(Residence in Baltimore: No. 833 University Parkway St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, not stated (Month) (Day), 1892 (Year)

7-AGE 32 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Janitor
(b) General nature of industry, business, or establishment in which employed (or employer). 856

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), " "

12-MAIDEN NAME OF MOTHER " "

13-BIRTHPLACE OF MOTHER (State or Country), " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willie R. Jones

(Address) Fidelity Building

15- MAY 14 1917 ROBERT R. KRAUTER, Filed ..... 191.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 11 (Month) (Day), 1917 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest and autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest and autopsy (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Not stated acute primary brain
Destruction of brain tissue
Homicidal (Duration) 1 day yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
May 13, 1917 (Address) 1639 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 day yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, Mt. Auburn Cemetery

DATE OF BURIAL, May 14th 1917

20-UNDERTAKER Jno. W. Johnson

ADDRESS 1309 Druid Hill Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86934

CERTIFICATE OF DEATH.

90 D 86934

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 710 E 41 St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Eversman

(a) Residence No. 710 E 41 St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Callaway.

6-DATE OF BIRTH (month, day and year) Oct 22 1867

7-AGE. 56 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Commission Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Mardella Springs Md

PARENTS.

10-NAME OF FATHER James Eversman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eliza Lloyd

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Julia Eversman

(Address) 710 E 41 St

MAY 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/12/1924

17- I HEREBY CERTIFY, That I attended deceased from April 30 1924, to May 12, 1924

that I last saw h~~im~~ alive on May 11 1924

and that death occurred, on the date stated above, at 4:10 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart

Contributory Arteriosclerosis

(Durntion) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W S Gant M. D.

5/13, 1924 (Address) 1111 N. Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL, May 14, 1924

20-UNDERTAKER, John Elliott

ADDRESS 20 E Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

See Letter in file of July 3rd 1924 from Doctor Hawkins

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86935

CERTIFICATE OF DEATH.

101-001

D 86935

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Ridgley St. St. Ward 25)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Smith

(a) RESIDENCE. No. 119 Ridgley St. St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Smith

6 DATE OF BIRTH (month, day, and year) July 13, 1887 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	~~28~~	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Lucy Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Augusta Butler (Address) 5/12 Same

MAY 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/7/ 1924. to 5/11/ 1924.

that I last saw him alive on 5/10/ 1924.

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. Hawkins M. D.

5/12 1924 (Address) 917 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	5/14 1924

20 UNDERTAKER Samuel Hamilton ADDRESS 1811 Pa. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 B 200 86936

CERTIFICATE OF DEATH.

100 D 86936

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Arthur

(a) RESIDENCE NO. 617 S Eutaw ST. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Nov 17 1917

7 AGE — Years: 4 — Months: 5 — Days: 26 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Steven Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rose Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Record

15 Filed ..... 19 .....

ROBERT N. KRAUTER, Registrar

MAY 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13, 1924

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1924 to May 13, 1924.

that I last saw her alive on May 13, 1924.

and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Empyema

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary): Multiple Abscesses

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? 617 S. Eutaw St

Did an operation precede death? Yes Date of 5/5/24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Hugh N. Cornell, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: May 14 1924

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 4033 Hoffman

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86937

CERTIFICATE OF DEATH.

188-002 D 86937

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Banks.

(a) RESIDENCE No. 1719 Maryland. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
36 Years	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Via.

PARENTS

10 NAME OF FATHER green Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Via

12 MAIDEN NAME OF MOTHER Minnie Bant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Via

14 Informant Allen Banks
(Address) 1719 Maryland ave

15 Filed , 192

MAY 14 1924

HUBERT K. KRAUTH
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures

(duration) yrs. mos. 1 hr. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

(Signed) Geo C. Blades M. D.

(Coroner)

5/14/24 192 (Address) 48 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery May

DATE OF BURIAL 14th 1924

20 UNDERTAKER Wm R. H. Elliott. 1725

ADDRESS Arland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86938

CERTIFICATE OF DEATH.

101-91 ✓ 86938

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 Penn Ave St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward J. Campbell

(a) Residence No. 1114 Penn Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 1852

7-AGE, 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, William Campbell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Isaac

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mrs Kate Campbell

(Address) 1114 Penn Ave

15-

Filed ....., 192 ROBERT R. KRAUTER, Registrar.

MAY 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 13 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 13, 1924, that I last saw him alive on May 13, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
St Marys Hampden	May 15, 1924
20-UNDERTAKER	ADDRESS
Wm Cook	502 E Lt. Ave

IMPORTANT—Physicians and Undertakers should be careful to see that the Name, Age, Residence and Cause of Death are stated EXACTLY. PHYSICIANS should be stated CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

MICHAEL HESS.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86939

CERTIFICATE OF DEATH.

118-002 D 86939

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument & Rutland Sts. WARD 27)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Hess

(a) RESIDENCE NO. 10 E. Biddle St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Hess

6 DATE OF BIRTH (month, day, and year) March 5, 1856

7 AGE Years 66 Months 2 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe

(c) Name of employer Merchant

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Louis Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Louis Hess

(Address) Lake Drive

15 MAY 14 1924 ROBERT R. KRAUTH, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 12 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/12, 19 24, to 5/12, 19 24.

that I last saw h... alive on 5/12, 19 24.

and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) 1 hr

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/12/24

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) A. Adler-Sondheimer M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 5/14/1924

20 UNDERTAKER David Sondheimer

ADDRESS 118-20 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86940 CERTIFICATE OF DEATH. 161-001 D 86940

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sampson

(a) RESIDENCE NO. 102 N. Eden St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1/3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 24, 1924

7 AGE	Years	Months	Days	If LESS than 1 day 8 hrs. or ..... min.
	8 hrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER George Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Sampson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital

Filed MAY 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch 24, 1924 to Mch 24, 1924.

that I last saw him alive on Mch. 24, 1924,

and that death occurred, on the date stated above, at 9-53 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) W. W. Bray, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAY 14 1924

20 UNDERTAKER: Commissioner Health — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86941

CERTIFICATE OF DEATH.

161-0 D 86941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Railey.

(a) RESIDENCE NO. 22 Montgomery. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Milton Railey.

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Fannie Beall

13 BIRTHPLACE OF MOTHER (city or town) Washington D C (State or country)

14 Informant Johns Hopkins Hospital (Address)

15 Filed MAY 14 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to May 8, 1924, that I last saw her alive on May 8, 1924, and that death occurred, on the date stated above, at 7 10 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Susan P. Souther, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	MAY 14 1924
20 UNDERTAKER Commissioner of Health.	ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D 86942

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓ D 86942

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wilcox

(a) RESIDENCE No. 837 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 25, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~ 000

(b) General nature of industry, business, or establishment in which employed (or employer) ~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Frances Cavey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Naidine Wilcox

13 BIRTHPLACE OF MOTHER (city or town) W. Va. (State or country)

14 Informant (Address) Johns Hopkins Hospital

15 Filed MAY 14 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mch 25, 1924, to Mch 27, 1924, that I last saw him alive on Mch 27, 1924, and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. P. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86943

CERTIFICATE OF DEATH.

3/ D 86943

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Winston

(a) RESIDENCE NO. 1119 Bolton St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Jan 3, 1922

7 AGE: Years 2 Months 4 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): H

(c) Name of employer: H

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Winston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ella King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Record.

JOHNS HOPKINS HOSPITAL

MAY 14 1924 Filed

ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924 to May 14, 1924.

that I last saw her alive on May 11, 1924,

and that death occurred, on the date stated above, at 11 00 P m.

The CAUSE OF DEATH* was as follows: Tuberculous Meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Acute Miliary Tuberculosis

(duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Thos. R. Brugg M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 5-15-24

20 UNDERTAKER: Dan'l Easton

ADDRESS 916 Ca av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86944

CERTIFICATE OF DEATH.

4 162 ✓ 86944

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 733 Sarah Ann St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Golden Smith Jr.

(a) Residence No. 733 Sarah Ann St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	Col	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 12, 1924

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 5 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... ditto

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Golden Smith

11-BIRTHPLACE OF FATHER (city or town). Winder
(State or Country), Ga

12-MAIDEN NAME OF MOTHER, Rosa Brown

13-BIRTHPLACE OF MOTHER (city or town). Warrington
(State or Country), Fla

14- (Informant) Mr. Golden Smith
(Address) 733 Sarah Ann

15- Filed MAY 14 1924 ROBERT R. KRAUTER (Registrar)
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 12 1924

17- I HEREBY CERTIFY, That I attended deceased from May 12, 1924 to May 12, 1924, that I last saw him alive on May 12, 1924, and that death occurred, on the date stated above at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis
(5½ hrs)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. L. Cooley M. D.

, 19 (Address) 733 Sarah Ann

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) **whether Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Mt Auburn Cem.	5-15-, 19 24
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 86945

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Wayne ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James D. Brooks

(a) RESIDENCE. No. 604 Wayne ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Brooks

6 DATE OF BIRTH (month, day, and year) Feb 28 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84	[illegible]	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co. Md.

PARENTS

10 NAME OF FATHER Jas. Brooks Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henny Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) 604 Wayne Ave Caroline Conrad

15 [illegible]

MAY 14 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 / 1924

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1923, to May 12, 1924, that I last saw him alive on May 11, 1924, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 12 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H. Fahrmire M. D.

(Address) 1017 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	May 14 1924
20 UNDERTAKER	ADDRESS
Jno Groff & Son	408 N. Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86946 HEALTH DEPARTMENT—CITY OF BALTIMORE D 86946

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 W. Oxford St., 21 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm H. Parker

(a) RESIDENCE NO 809 W. Oxford St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Nancy Parker

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	About 65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) Annapolis, Md
(State or country)

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harriet Parker
(Address) 223 N. Appleton St.

15 Filed MAY 14 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1924

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchial Asthma
4 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart Failure
(duration) yrs. mos. ds.

(Signed) Thos. E. Hopkins M. D.
May 14 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional items.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 14 1924
20 UNDERTAKER	ADDRESS
Pearce Redmond & Schroder	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Hoos)

Home 6893

D 36947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36947

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1612 E. Eagan st 8 Ward)

Registered No. 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elmer Hoos

(a) Residence No. 1612 E. Eagan st St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) April 11 1923

7-AGE, 1 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country).

PARENTS.

10-NAME OF FATHER. Elmer M. Hoos

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country).

12-MAIDEN NAME OF MOTHER. Elsie Ruff

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country).

14- (Informant) Elmer M. Hoos

(Address) 1612 E. Eagan st

15- MAY 14 1924 ROBERT R. KRAUTER, Registrar.

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10 1924 to May 14 1924

that I last saw h[illegible] alive on May 13 1924

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Nasal)

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture.

(Signed) Wm McNutt, M. D

May 14, 1924 (Address) 701 Wakewood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery

DATE OF BURIAL. May 14 1924

20-UNDERTAKER. George F. Ruth

ADDRESS 1735 Harford Ave

N. B.—WHERE PERMIT WILL BE REQUIRED, IT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86948

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Bay View Hospital 3 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lloyd.

(a) Residence No. 328 S. Dallas St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Blk.	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) ~~1894~~ 1880

7-AGE. 30 ~~43~~ yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 137

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Do.

14 (Informant) Bay View Hospital

(Address) Baltimore, Md.

15 Filed ..... 192 ..... Registrar.

MAY 14 1924

Robert F. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/12/24.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1924 to May 11, 1924

that I last saw her alive on May 11, 1924

and that death occurred, on the date stated above, at 9-15 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Paralysis Insane

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical + autopsial findings

(Signed) H. H. Holmes M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. ..... DATE OF BURIAL, 5-14-24

20-UNDERTAKER. Commissioner Health. ADDRESS

UNIVERSITY OF MARYLAND

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Statement of OCCUPATION is very important. AGE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAKING A FALSE ENTRY IN THIS RECORD IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86949

CERTIFICATE OF DEATH.

100-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hixon or Hickson

(a) RESIDENCE NO. Bay View asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address) UNIVERSITY OF MARYLAND

15 Filed 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-1, 1922 to 5-11, 1924 that I last saw him alive on 5-11, 1924, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Dines, M. D.

5-12, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAY 14 1924

20 UNDERTAKER Bureau of Health, per. Wm. E. WOODALL

ADDRESS

D 86950

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D 86950

REGISTERED No. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 922 Gorsuch ave ST.: 9 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Fenton

(Residence in Baltimore: No. 921 Gorsuch ave ST.: 70 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: December 8th (Month), 1856 (Year)

7 AGE: 77 yrs. 5 mos. 4 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9 BIRTHPLACE (State or country): Ireland

PARENTS

10 NAME OF FATHER: Christopher Fitzsimmons

11 BIRTHPLACE OF FATHER (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Crawford

13 BIRTHPLACE OF MOTHER (State or country): Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna V. Eckhardt

(Address) 922 Gorsuch Ave.

15 Robert ... 191 ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 12 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1924 to May 12 1924

that I saw her alive on May 10, 1924

and that death occurred, on the date stated above, at 8 0 m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Myocarditis

(Duration) 1 yrs. 1 mos. ... ds.

(Signed) James M Fenton, M. D.

May 13, 1924 (Address) 709 E Chase

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mer Cathedral Cem — DATE OF BURIAL: May 15 1924

20 UNDERTAKER: Joseph. B Cook — ADDRESS: 1003 N. Eutaw St

MAY 14 1924 Burial Permit Clerk

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86951

49 D 86951

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1753 Homestead ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Ripken

(a) RESIDENCE. NO. 1753 Homestead ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Ripken

6 DATE OF BIRTH (month, day, and year) Feb 24 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Ripken (Address) 2537 N Fair mount St

15 Filed . 19 Robert P. Harris, Registrar

MAY 14 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-13 19 24

17 I HEREBY CERTIFY, That I attended deceased from April 24, 19 24, to May 13, 19 24, that I last saw her alive on 5-13-, 19 24, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Daniel Miller, M. D.

. 19 (Address) 1506 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cem	May 15 1924
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86952

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 715 Lennox St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Grace Knowles

(a) Residence No. 715 Lennox St., 13 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? 5 yrs. 10 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) July-9-1918

7-AGE, 5 yrs. 10 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Jas. A. Knowles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Mary B. Kirkpatrick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Greensboro N. C.

14-Informant Mr. J. A. Knowles-Father

(Address) 715 Lennox St

15-Filed MAY 14 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May-13-1924.

17-I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 13, 1924.

That I last saw h.. alive on May 13, 1924.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) 2 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Irvine Eberaugh, M. D.

May 14, 1924 (Address) 700 N Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Mount Cemetery — DATE OF BURIAL, May-15 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

WHITE PENCIL, WITH UNFADING INK. Entries must be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 630 N. Dulmor St. St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Wm Sewell Isaacs

(a) Residence No. 630 N. Dulmor St. St.,.....Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Isaacs

6-DATE OF BIRTH (month, day and year) Apr 30 1840

7-AGE. 84 yrs. 0 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Jonathan Isaacs

11-BIRTHPLACE OF FATHER (city or town).....(State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ann Thompson

13-BIRTHPLACE OF MOTHER (city or town).....(State or Country), Unknown

11- (Informant) Mrs. Clinton Summers

(Address) Greenway & Bedford Sq.

15- Filed MAY 14 1924, 19..... Robert P. Harrison, Registrar.

Burial Permit Work

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr 15, 1924 to May 14, 1924 that I last saw him alive on May 14, 1924 and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Uraemia - Senile gangrene

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Cystitis

(Duration) four yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test or

(Signed) M. Bauman and Lewis M. D

May 14, 1924 (Address) 626 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	May 15 1924
20-UNDERTAKER.	ADDRESS
Wm J. Tickner & Sons	North Ave

MAY 14 1924

1—WHITE PENCIL, WRITE ONLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Terms should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Terms should be in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 86954

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Belmont Ave & Poplar St., Ward 15)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Deane

(a) RESIDENCE No. 1720 Poplar Grove St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 6 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1908.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15 yrs.	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jno. F. Deane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Ely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jno. F. Deane
(Address) 1720 Poplar Grove St.

15 Filed MAY 14 1924, 192 Robert P. Garrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

crushing injuries to chest, abdomen, fracture of skull & death.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) automobile accident

(duration) ... yrs. ... mos. ... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 14, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. W. Klagsyn	May 15, 1924
20 UNDERTAKER Chr. W. Little	ADDRESS 2802 Edmondson Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.—WRITE PLAINLY, WITH UNFADING INK—

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86955 HEALTH DEPARTMENT—CITY OF BALTIMORE 47 D 86955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1425 Harling ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Katie P. Palmer

(a) Residence No.... 1425 Harling ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Earl D Palmer

6-DATE OF BIRTH (month, day and year): Nov 24 1896

7-AGE: 27 yrs. 5 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): MD

PARENTS.
10-NAME OF FATHER: Emanuel Phillips
11-BIRTHPLACE OF FATHER (city or town) (State or Country): MD
12-MAIDEN NAME OF MOTHER: Parkinson
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): [illegible]

11-(Informant): Earl D. Palmer
(Address): 1425 Harling ave

15-Filed ....., 19..... Robert P. Harrison, Registrar.

MAY 14 1924 [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 14

17- I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 14, 1924, that I last saw her alive on May 13, 1924, and that death occurred, on the date stated above, at 3 30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma

(Duration) ..... yrs. 8 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) Frank H. Mackin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL, May 17, 1924

20-UNDERTAKER: CHENOWETH & SON — ADDRESS 3617 CHESTNUT AVE.

...ed EXACTLY. PHYSICIANS should state CA... DE... should be carefully supplied. AGE should be stated EXACTLY. In plain terms, so that it may be properly classified. ...ied. Exact statement of OCCUPATION is very important. ...e instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86956

D 86956

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3602 Parkedale Ave Ward 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mabel V. Boone

(a) Residence No..... 3602 Parkedale Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed or divorced HUSBAND of (or WIFE of) Charles Boone

6-DATE OF BIRTH (month, day and year) March 8 1884

7-AGE, 40 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER John Fantom

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Emeline McGee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Charles Boone

(Address)..... 3602 Parkedale Ave

15- Filed MAY 14 1924 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12 1924

17- I HEREBY CERTIFY, That I attended deceased from May 6th, 19 24, to May 12th, 19 24

that I last saw h alive on May 12th, 19 24,

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Jno. Hundley Rawls, M. D.

5/13, 19 24 (Address) 846 W 36th St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, May 15, 1924

20-UNDERTAKER, CHENOWETH & SON, ADDRESS 2117 GREENMOUNT AVE

WHITE PENCIL, WITH ONE BLOW, should state CAUSE OF DEATH EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86957

CERTIFICATE OF DEATH.

31 D 86957

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Warner ST., 27 WARD)

2-FULL NAME Charles P. Smith

(a) RESIDENCE NO. 700 Warner ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov-30-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	5	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work "Drive a 023

(b) General nature of industry, business, or establishment in which employed (or employer) yard East"

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country) —

12 MAIDEN NAME OF MOTHER Pinkey Gray

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant Cordelia Hughes
(Address) 736 Pabory St.

15 Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1924, to May 13, 1924, that I last saw him alive on May 13, 1924, and that death occurred, on the date stated above, at 11.10 a m.

The CAUSE OF DEATH* was as follows:

Chr Pulmonary Tuberculosis

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Swanson M. D.

5/13, 1924 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL May 15 1924

20 UNDERTAKER R. L. Parham

ADDRESS 902 Leadenhall

Spec.—1-10-21—M&T—1500 Bks.

D 86958

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 86958

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 Lemmon ST. 13 WARD)

2-FULL NAME Frank Ellis Corse

(a) RESIDENCE NO. 720 Lemmon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 1 ds. How long in U. S., If of foreign birth? always mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Sarah Matthews

6 DATE OF BIRTH (month, day, and year) Jan 6 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurseryman

(b) General nature of industry, business, or establishment in which employed (or employer) Nursery

(c) Name of employer Himself

9 BIRTHPLACE (city or town) Gardenville
(State or country) Balto Co.

PARENTS

10 NAME OF FATHER William Corse

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sinclair

13 BIRTHPLACE OF MOTHER (city or town) Gardenville
(State or country) Md.

14 Informant Mary E. Corse
(Address) 720 Lemmon St.

15 Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1923, to May 13, 1924, that I last saw him alive on May 13, 1924, and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach.

(duration) 1 yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Austin F. Robinson M. D.

5/17 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Gunpowder Friends Cemetary. DATE OF BURIAL 5/15 1924

20 UNDERTAKER William C. Brooks ADDRESS Sharpsburg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86959

CERTIFICATE OF DEATH.

1824 D 86959

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Arthur L. Baker

(a) RESIDENCE NO 502 Sheridan ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 166
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Elizabeth Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emily Christopher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Arthur L. Baker
(Address) 502 Sheridan ave Balto Md

15 Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) 3 hours

CONTRIBUTORY (Secondary) Fell in Elevator Shaft

(duration) yrs. mos. ds.

(Signed) H. H. Gorsuch, M. D.
(Coroner.)

5-14, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Preston Md	May 18 1924
20 UNDERTAKER George J. Smith	ADDRESS 153 Hollins

NO. 2.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 86960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86960

74001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 W Biddle ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Earp

(a) RESIDENCE NO. 22 W Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 9 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa

PARENTS

10 NAME OF FATHER Geo. Earp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Elizabeth Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Dr. Whitridge Williams

(Address) Howard & Eutaw Sts

15 Filed MAY 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17

I HEREBY CERTIFY, That I attended deceased from May 23 1923, to May 10, 1924, that I last saw h alive on April 5. 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. H. Pearce M. D.

, 19 (Address) 2105 N Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa.

DATE OF BURIAL May 15 1924

20 UNDERTAKER Henry W. Jenkins Sons

ADDRESS McCulloh & Orchard Sts

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86961

CERTIFICATE OF DEATH.

45 D 86961

1-PLACE OF DEATH 849 Harlem ave

CITY OF BALTIMORE: (No. 849 Harlem Ave ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte J. Rea

(a) RESIDENCE NO. 849 Harlem ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2nd 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance Co

(c) Name of employer Maryland Casualty Co

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER James A. Rea

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Anna Eliza Leonard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) York Co. Penn

14 Informant Anna M. Rea
(Address) 849 Harlem Ave

MAY 15 1924

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28th, 1923, to May 13th, 1924, that I last saw her alive on May 13th, 1924 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Lower bowel, General metastasis through the lymph channels

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic exam. and X-ray

(Signed) Armand T. Morris, M. D.

, 19 (Address) 110 E. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 5/16 1924

20 UNDERTAKER L. W. Meaver Son

ADDRESS Balto Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86962

CERTIFICATE OF DEATH.

47 D 86962

D 86962

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Eutaw Place ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Laura Cohen

(a) RESIDENCE NO. 2001 Eutaw Place ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Cohen

6 DATE OF BIRTH (month, day, and year) Sept. 26/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 400

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Lauer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Sophia Recondorf

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Harold Cohen (Address) 2001 E P

15 Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb'y May 28, 1924, to May 14, 1924, that I last saw h[illegible] alive on May 13, 1924, and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. 4 mos 0 ds.

CONTRIBUTORY (Secondary) Mediastinal glandular metastases, Pulmonary metastases

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Radioscopic

(Signed) Louis P. Hamburger M. D.

May 14, 1924 (Address) 20 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai — DATE OF BURIAL May 16 1924

20 UNDERTAKER David Sondheim — ADDRESS 1182 W Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

86963

HEALTH DEPARTMENT—CITY OF BALTIMORE

86963

CERTIFICATE OF DEATH.

1924

1-PLACE OF DEATH CITY OF BALTIMORE (No. Mercy Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Cohen

(a) RESIDENCE NO. 811 Brooks Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Cohen

6 DATE OF BIRTH (month, day, and year) Jan 1 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jewelry
(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 Eutaw

15 Filed MAY 15 1924 ROBERT H. KRAUTER, Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot wound of Skull
Homicide

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. 1/2 ds.

(Signed) [illegible] M. D.
(Coroner)

5/14/24, 192 (Address) 1432 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	5/15 1924
20 UNDERTAKER Jack Lewis 1439	ADDRESS Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86964

CERTIFICATE OF DEATH.

129 D 86964

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2100 E. Balto. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alter Kanner

(a) Residence No. 2100 E. Balto. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Kanner

6-DATE OF BIRTH (month, day and year)

7-AGE. 44 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town)
(State or Country) Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)
(State or Country) Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country) Russia

11- (Informant) Jack Lewis
(Address) 1439 E. Balto St.

15- Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 14. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 7 1924 to May 14 1924
that I last saw h[illegible] alive on May 14 1924
and that death occurred, on the date stated above, at 12.0 m.
The CAUSE OF DEATH* was as follows:

C. Nephritis

(Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Whitehouse M. D.
(Address) 910 Eutaw Pl.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Friendship Cem	5/16 1924
20-UNDERTAKER.	**ADDRESS**
Jack Lewis	1439 E Balto St

R. B.—WRITE PLAINLY, WITH UNFADING INK. ALL ITEMS must be answered. Every item should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 86965

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Carey St ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Callen

(a) RESIDENCE NO. 314 N. Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph M Callen

6 DATE OF BIRTH (month, day, and year) March 30, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Cushman Stockins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Ethna Bell Thorpe

(Address) 314 North Carey St

Filed MAY 15 1924 ROBERT R. KRAUER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to May 14, 1924, that I last saw her alive on May 7, 1924, and that death occurred, on the date stated above, at 5-55 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 1 mos 0 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis & Senility

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Usual

(Signed) Ed Kemmler, M. D.

5-14 1924 (Address) 1409 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL May 23 1924

20 UNDERTAKER J. H. Cook ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86966

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 E. 22½ St. ST., 9 WARD)

2-FULL NAME Charles Fr. Smith.

(a) RESIDENCE NO. 402 E. 22½ St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) September 23/93

7 AGE — Years: 30 — Months: 7 — Days: 17 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Robert E. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Martha Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Grace Skinner
(Address): Schuylkill Co Pa

15 Filed ..... 19 .....

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk

MAY 15 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month and year): May 14th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 29th, 1924, to May 14th, 1924.

that I last saw him alive on May 14th, 1924

and that death occurred, on the date stated above, at 4.10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Washington Boyd M.D. M. D.

5/15, 1924 (Address) 501 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mon Co Memorial Gardens — DATE OF BURIAL: 5-16 1924

UNDERTAKER: Helen A Holland — ADDRESS: 1631 Division Hilland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86967

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 86967

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Hollins ST.: 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Colley

(a) RESIDENCE. NO. 2105 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Colley
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3/1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jno W. Colley

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Mollie A Sheats
(Address) 2105 Holland St.

15 Filed MAY 15 1924 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) May 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 12 1924.

that I last saw h alive on May 12 1924.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

5/13 1924 (Address) 3207 Wash

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 15 1924
20 UNDERTAKER	ADDRESS
George L. Schwab	216 Park Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86968

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86968

CERTIFICATE OF DEATH.

Registered No. 15 21

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Cronhardt

(a) Residence No. 2700 Roslyn Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Cronhardt

6-DATE OF BIRTH (month, day and year) 1844

7-AGE. 80 yrs. 6 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer). 015

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore Co.,
(State or Country). Md.

PARENTS.

10-NAME OF FATHER, Henry Cronhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Henriette C. Schmeck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Municipal Hospital Record

(Address)

15- MAY 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-13-24

17- I HEREBY CERTIFY, That I attended deceased from 5-7, 1924 to 5-13 1924

that I last saw him alive on 5-13, 1924

and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude G. Wrack M. D.

5-13, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Louis Chestnut Ridge Cem. Co.

DATE OF BURIAL. May 16, 1924

20-UNDERTAKER. George L. Schmeck

ADDRESS 2101 Eutaw Ave.

Spec.—1-10-21 M&T 1500 Bks.

D 86969

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 Fremont St., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Lillian Heyer

(a) RESIDENCE No. 440 Fremont St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 18. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Ernest Heyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Swan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Julia Heyer
(Address) 440 Fremont St

15 Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 15, 1924.

that I last saw her alive on May 15, 1924.

and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever.
Diphtheria.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Endocarditis & Pulmonary Oedema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Welch M. D.

5/15/24 (Address) 215 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL May 16 1924

20 UNDERTAKER C. W. Dill

ADDRESS 9109 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. (Matthew J Harley)

D 36970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 36970

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1122 Port St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Harley

(a) Residence No. 1122 Port St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-Single, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Martha Harley

6-DATE OF BIRTH (month, day and year) Jan 17 1882

7-AGE, 42 yrs. 3 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) 040
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Martha Harley (Address) 1122 Park St.

15- Filed MAY 15 1924, 192.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 12 10. A.M. 1924 to May 12 1924

that I last saw h.. alive on May 12 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia —

(Duration) yrs. mos. 5 hours ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By Ext

(Signed) R. Harold Schmelz M. D.

May 14. 1924 (Address) 1304 - D. H.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Ashley Cemetery	May 15 1924
20-UNDERTAKER.	ADDRESS
Mac P. C. Elliott	1720 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86971

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 86971

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Himmelheber

(a) RESIDENCE NO. 2100 E. Gough ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed MAY 15 1924, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-26, 1924, to 5-14, 1924, that I last saw him alive on 5-13, 1924, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Syphilitic aortitis
Aortic insufficiency
Myocardial insufficiency

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab ~~Autopsy~~

(Signed) Claude S. Brown, M. D.

5-14 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	May 16 1924
20 UNDERTAKER	ADDRESS
Louis Heeman	324 Broadway

Spec.—1-10-21—M&T—1500 Bks.

Sienkiewicz

86972

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
D 86972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 S. Patterson Park Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph ~~Edmund~~ Sienkiewicz

(a) RESIDENCE NO. 208 S. Patterson Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	4	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Peter Sienkiewicz

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Wisniewski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant W. Wisniewski
(Address) 208 Patterson Park Ave

Filed MAY 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6 1924, to May 18 1924,
that I last saw him alive on May 12 1924,
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
Dry Pleurisy, Pericarditis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) A F Reis, M. D.

May 14, 1924 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	5/16/24 19
20 UNDERTAKER F. W. Ozog zurski	ADDRESS 1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 86973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 ✓

D 86973

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (If death occurred in a hospital or institution, give its NAME instead of street and number.) NO. 429 E Fillmore ST.: 24th WARD)

2-FULL NAME Charles Neal

(a) RESIDENCE. NO. 429 E Fillmore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/13/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Tashman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) James Neal 429 E Fillmore St

15 Filed MAY 15 1924 16 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/13/24, 19..., to 5/14, 19 24, that I last saw h[illegible] alive on 5/13, 19 24, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 0/ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Brunicardi, M. D.

May 17, 1924 (Address) 1277 Williams

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co	5-15-1924
20 UNDERTAKER	ADDRESS
E T Slade	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86974

CERTIFICATE OF DEATH.

4 181-001 ✓ D 36974

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 104 N. Gilmor St ST., 4 WARD)

2-FULL NAME C. M. Whitney

(a) RESIDENCE NO 104 N Gilmor St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Don't Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	5-0			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Don't Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Home
(Address)

15 MAY 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonitis Gas Inhalation

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental

(duration) ✓ yrs. mos. ds.

(Signed) A K Yeager, M. D.
(Coroner.)

5/14, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL MAY 15 1924

UNDERTAKER ..... ADDRESS .....

Commissioner of Health,
Per. WM. F. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Apvd. 1 10 21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86975

D 86975

32

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Warner ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Selina Krampe

(a) RESIDENCE NO. 1006 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 27, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph A. Krampe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Dora Bock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Joseph A. Krampe

(Address) 1006 Warner St.

15 MAY 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from April 24th, 1924, to May 13th, 1924.

that I last saw h[illegible] alive on May 13th, 1924.

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Examination Spinal Fluid

(Signed) J. F. Potter M. D.

5/14/24 (Address) 3709 Gunston Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL May 16. 1924

20 UNDERTAKER Mr & Mrs John H Teufel & Son ADDRESS 801 W Fayette St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 86976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86976

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Riggs St. 16 WARD)

2-FULL NAME Mrs. Mary Johnson

(a) RESIDENCE. NO. 1614 Riggs St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Johnson

6 DATE OF BIRTH (month, day, and year) May 2- 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Early Heights, Anne Arundel Co., Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Chas. C. Manns

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co., (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Samuels

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co., (State or country) Md.

14 Informant Mrs. Cora E. Jones
(Address) 1614 Riggs Ave.

MAY 5 1924

Filed 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28th 24, to May 13th 24,

that I last saw h[er] alive on May 13th 24,

and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
5 Mins.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy
(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jas. E. Beall M. D.

19 (Address) 1124 Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Robinson Stall a. Colrd

DATE OF BURIAL May 16th 1924

20 UNDERTAKER A. Jones

ADDRESS 111 S. Gilmor St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86977

D 86977

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 509 N. Norris ST.: 19 WARD)

2-FULL NAME Charles Kessler

(a) RESIDENCE. NO. 509 Norris ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Minnie Kessler

6 DATE OF BIRTH (month, day, and year) Nov 1-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Minnie Kessler
(Address) 509 N. Norris

Filed MAY 15 1924 19 Robert F. Garrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924 to May 13, 1924

that I last saw him alive on May 13, 1924

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Robert F. Garrison, M. D.

May 15 (Address) 1111 Fort Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 16th 1924
20 UNDERTAKER A. Jones	ADDRESS 111 S. Gilmor St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86978

CERTIFICATE OF DEATH.

X 90 D 86978

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Cathedral ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretta B. Speers

(a) RESIDENCE NO. 700 Cathedral ST., WARD Early Heights Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 2- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon P. Speers

6 DATE OF BIRTH (month, day, and year) Nov. 26 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~

(b) General nature of Industry, business, or establishment in which employed (or employer) ----------

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Louis M. Speer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Jane Finley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mary W. F. Speers

(Address) 700 Cathedral St.

15 Filed MAY 15 1924 . 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24th, 1924, to May 12th, 1924, that I last saw h[illegible] alive on May 12th, 1924, and that death occurred, on the date stated above, at 7 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No Date of ----

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer, M. D.

May 14th, 1924 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	May 16, 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

D 86979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86979

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4006 Groveland Ave. ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Ross

(a) RESIDENCE NO. 4006 Groveland Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Ross

6 DATE OF BIRTH (month, day, and year) Oct 5, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John T. Ross.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Teresa Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James L Ross 4006 Groveland ave

15 Filed MAY 15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 14, 1924,

that I last saw him alive on May 14, 1924,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) Fractured rib & pleurisy

(duration) — yrs. — mos. 3 ds. (about)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Dr. B. Lemon, M. D.

5-15-1924 (Address) 5016 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL 5/16 1924

20 UNDERTAKER J. J. Moran ADDRESS 2000 E. Belvedere

A.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86980

CERTIFICATE OF DEATH.

100-001 ✓

D 86980

Registered No.....

1-PLACE OF DEATH 313

City of BALTIMORE, (No. ~~219~~ Scott St. St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet L. Krebs.

(a) Residence No. 217 Scott St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dan'l Krebs

6-DATE OF BIRTH (month, day and year) July 14 1863

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home duties 3

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balt Md

PARENTS.

10-NAME OF FATHER, Mr. Peacock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Ann Susan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Mrs Kate Lee

(Address) 217 Scott St

15- Filed MAY 15 1924 Robert F. Garrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 14 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 24 to May 14 24

that I last saw h. alive on May 14 24

and that death occurred, on the date stated above, at 9:25 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 2 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Auto Intoxication

Nephritis (Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Friedinger M. D.

5/15, 19 24 (Address) 682 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	5/17 19 24
20-UNDERTAKER,	ADDRESS
W. P. Cook	502 E Nat

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Dr Hennessey
Edmondson Av.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86981

66 D 86981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE (No. Hillsdale 11rd ST., 28 Windsor Mill Rd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Kelley

(a) RESIDENCE NO. Hillsdale 11rd ST., Windsor Mill Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Caroline Kelley

6 DATE OF BIRTH (month, day, and year) May-1-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	0	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) City
(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bryandt Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Caroline Kelley
(Address) Hillsdale Md

15 Filed MAY 15 1924, 192 Robert P. Garrison, Registrar
Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. T. Hennessey, M. D. (Coroner.)

May 15, 1924 (Address) 280 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 5/17 1924

20 UNDERTAKER Sullivan Co — ADDRESS 502 E Lexington

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 1845 Covington St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.. Isabell A Lee

(a) Residence No... 1845 Covington St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Divorced

5a-If married, ~~widowed~~ or ~~divorced~~ HUSBAND of (or) WIFE of Andrew Lee

6-DATE OF BIRTH (month, day and year) Dec 21/1850

7-AGE, 74 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cook

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Dorchester Co Md

PARENTS.

10-NAME OF FATHER Capt. Thomas Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Dorchester Co Md

12-MAIDEN NAME OF MOTHER Isabell Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Dorchester Co Md

14- (Informant) Mrs Alvary Black

(Address) 1613 Jackson Street

15- Filed MAY 15 1924 Robert P. Harris Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 14/24

17- I HEREBY CERTIFY, That I attended deceased from May 12/24, 19..., to May 14, 19 24.

that I last saw her alive on May 14, 19 24.

and that death occurred, on the date stated above, at 7 15 p m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Indigestion

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Ar. Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry Thomas Cleaver M. D.

May 14 1924 (Address) 933 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem't

DATE OF BURIAL: May 16 19 24

20-UNDERTAKER: William Cadden & North Co

ADDRESS

Burial Permit Clerk

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 36983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1919 N Regester St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Laura B. Alexander

(a) Residence No. 1919 N Regester St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, white

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ John Alexander

6-DATE OF BIRTH (month, day and year) May 31, 1848

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 600

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Harryman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), England

12-MAIDEN NAME OF MOTHER, Caroline Harryman

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), England

14-(Informant)..... (Address)..... 7733 N Calvert St

15-Filed MAY 15 1924 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15 24

17- I HEREBY CERTIFY, That I attended deceased from Apr. 24-24, 19..., to May 15, 19 24

that I last saw her alive on May 15, 19 24

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. E. Burnstock M. D.

5-25-1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Rock Spring Md — DATE OF BURIAL, May 17, 1924

20-UNDERTAKER, Edw Tuttle for — ADDRESS Towson Md

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(John)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86984

CERTIFICATE OF DEATH.

113

D 86984

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 144 Loudan Av ST., 70 WARD)

2-FULL NAME Mary Audrey Sohn

(a) RESIDENCE NO. 144 Loudan Av ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. 5 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 16 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Sohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Nellie Beam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt—

14 Informant Harry Sohn

(Address) 144 Loudan Av

15 Filed MAY 15 1924, 19... Registrar Robert F. Garrison

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to May 14, 1924, that I last saw h... alive on May 14, 1924, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation - Stillborn

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Howard W Jones, M. D.

(Address) 222 Long Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 16 1924
20 UNDERTAKER	ADDRESS
F. A. Keppler	222 Fairfax Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86985

CERTIFICATE OF DEATH.

74-001 D 86985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Eastern av ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melissa Williams

(a) RESIDENCE NO. 1413 Eastern av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Williams

6 DATE OF BIRTH (month, day, and year): Jan. 22/1869

7 AGE: Years 55 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Thomas Sturgis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Geo. Williams

(Address): 1413 Eastern av

Filed MAY 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1924

17

I HEREBY CERTIFY, That I attended deceased from March 3rd, 1924, to May 14th, 1924,

that I last saw her alive on May 13th, 1924

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Landreth, M. D.

May 15th, 1924 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Cemetery

DATE OF BURIAL: May 17 1924

20 UNDERTAKER: Geo. J. Rust

ADDRESS: 1735 Harford av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

86986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 86986

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1620 Keyser ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas Robt Peterson

(a) RESIDENCE NO. 1620 Keyser ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson A. Rote

6 DATE OF BIRTH (month, day, and year) 6/15 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hammerer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER John Brictson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. County

12 MAIDEN NAME OF MOTHER Ireen Shirley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt County

14 Informant Nelson A. Rote

(Address) 1620 Keyser

15 MAY 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

I HEREBY CERTIFY, That I attended deceased from May 12, 1924, to May 14, 1924, that I last saw h[illegible] alive on May 14, 1924, and that death occurred, on the date stated above, at 11 00 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Wheelwright M.D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 17 1924
20 UNDERTAKER	ADDRESS
Geo. F. Rutt	735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86987

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 86987

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1928 E. Fayette St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August A. Knaup

(a) Residence No. 1928 E. Fayette St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Margarete Meurer

6-DATE OF BIRTH (month, day and year) Sept 3/1849

7-AGE. 74 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) House 66

(c) Name of employer F. Frank Novak Co.

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Ludwig Knaup.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amalia Geiger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs Hellen Stolle

(Address) 1928 E. Fayette

15- Filed MAY 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/14/1924

17- I HEREBY CERTIFY, That I attended deceased from May 7/ 1924 to May 14/ 1924

that I last saw h.... alive on May 14/ 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchorrea - asthenia

(Duration) — yrs. — mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. F. Roden M. D.

, 19 (Address) 1904 E. Fayette St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, May 17, 1924
Baltimore Cem	
20-UNDERTAKER, John Ulrich	ADDRESS 2008 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86988

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 1164 N. 10th St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John W. Horney .....

(a) Residence No. 1164 N. 10th St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louise Clasing

6-DATE OF BIRTH (month, day and year) Jan 21. 1863

7-AGE. 60 yrs. 3 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Thos Horney

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER Elizabeth Kinig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Louise Horney

(Address) 1164 N. 10th

15- FILED MAY 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 14 1924

17- I HEREBY CERTIFY, That I attended deceased from February, 1924 to May 13 1924

that I last saw him alive on May 13 1924

and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D

May 15, 1924 (Address) 2005 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cem	May 17, 1924
20-UNDERTAKER. John Allright	ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86989

CERTIFICATE OF DEATH.

49 D 86989

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3911 Liberty Heights ave. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gordon Milliken

(a) Residence No. 3911 Liberty Heights Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 3, 1914

7-AGE.	If LESS than 1 day,
9 yrs. 11 mos. 11 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... student

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer..... —

9-BIRTHPLACE (city or town)..... Baltimore
(State or Country), Md.—

PARENTS.

10-NAME OF FATHER. Robert C. Milliken

11-BIRTHPLACE OF FATHER (city or town)..... Balto
(State or Country), Md.—

12-MAIDEN NAME OF MOTHER. Mary M. Holland

13-BIRTHPLACE OF MOTHER (city or town)..... Balto
(State or Country) Md.—

14- (Informant) Robert C. Milliken

(Address) 3911 Liberty Heights

15- MAY 16 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14/24

17- I HEREBY CERTIFY, That I attended deceased from Apr. 17, 19 24 to May 14, 19 24

that I last saw him alive on May 14, 1924,

and that death occurred, on the date stated above, at 7.05 m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (Glioma) grand mal Bronchopneumonia of heart and respiratory

(Duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D.

5/15, 19 24 (Address) 2202 Harlem ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	May 17, 1924
20-UNDERTAKER.	ADDRESS
John Ottenstedt	1251 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86990

57 D 86990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Susan Grossman

(a) RESIDENCE NO. The Royal Apartments ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Anthony Grossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Helen E. Leggett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant P. H. Grossman

(Address) 819 Eastwood Ave

15 MAY 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15 1924

17

I HEREBY CERTIFY, That I attended deceased from 5-8, 1924, to 5-15, 1924.

that I last saw h.. alive on 5-15, 1924,

and that death occurred, on the date stated above, at 5 20 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus — coma ? ord

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms, blood sugar, urinalysis, etc.

(Signed) Morgan J. Phillips & M.D.

, 19 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL May 17 1924

20 UNDERTAKER — ADDRESS Geo. Ottenstein & Son, Liberty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Frank Abel.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 86991

86991

CERTIFICATE OF DEATH.

12

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 W. Register St.: 8 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Frank Abell

(a) RESIDENCE. No. 1718 Register St.. Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie M Abel

6 DATE OF BIRTH (month, day, and year) May 26th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Abel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sophia Abel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Bessie M Abel

(Address) 1718 Register st

15 MAY 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1924

17

I HEREBY CERTIFY, That I attended deceased from 4-21, 1924, to 5-14 1924

that I last saw h.. alive on 5-13 1924

and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows: Cirrhosis of liver (cause uncertain)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Fred Kuzicke, M. D.

5-15, 1924 (Address) 800 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 19 1924
20 UNDERTAKER	ADDRESS, 934
C Schlosser Sons	Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 23 (1924) 100 M.R.S.—400 Bks.

D 86992

HEALTH DEPARTMENT—CITY OF BALTIMORE

23

CERTIFICATE OF DEATH.

D 86992

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Arthur Bowman

(a) Residence No. 1031 N. Wolfe St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 40 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Steward

(b) General nature of industry, business, or establishment in which employed (or employer): 07

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Arkansas

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-(Informant) Municipal Hospital Records

Address:

15-FILED MAY 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-13-24

17- I HEREBY CERTIFY, That I attended deceased from 5-2 1924 to 5-13 1924

that I last saw him alive on 5-13 1924

and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(Duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Autopsy

(Signed) Claude G. Drane, M. D.

5-14, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
[redacted]	May 15, 1924
20-UNDERTAKER.	ADDRESS
Mrs. R. G. Elliott	1725 Eastlandon.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7181 D 86993

14 D 86993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Green

(a) RESIDENCE NO. 2028 Keyser St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Addie Green

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Nathanial S. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Randolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Addie Green

(Address) 2022 Keyser St

Filed MAY 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924 to May 14, 1924.

that I last saw h.. alive on May 14, 1924.

and that death occurred, on the date stated above, at 1 35 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach and peritoneum

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Exploratory operation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of May 10

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	May 16 1924

20 UNDERTAKER Mrs P. A. Elliott ADDRESS 1225 Oakland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 86994

D 86994

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Shane

(a) RESIDENCE NO. 101 N. Exeter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Shane

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jobber in old clothing

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harris Shane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Philip Shane

(Address) 34 N. Neal

15 MAY 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1924, to May 15, 1924, that I last saw him alive on May 15, 1924, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Bronchopneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor S. Fry M. D.

May 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery Run

DATE OF BURIAL 5/16 1924

20 UNDERTAKER John Lewis

ADDRESS 1409 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 86995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001 D 86995

1-PLACE OF DEATH 103 W 39th St

CITY OF BALTIMORE. (No. Hamlyn Apt ST., 12 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank. P. Woodside

(a) RESIDENCE NO. 103. W 39th St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 3. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 000

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William P. Woodside

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Partridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Warren Buckler
(Address): 806 Cathedral St

15 MAY 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1923, to May 15, 1924.

that I last saw him alive on May 15, 1924,

and that death occurred, on the date stated above, at 6-30 P. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia (duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage from Kidneys (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood examination

(Signed) Warren Buckler, M. D.

May 16 1924 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	May 17 1924
20 UNDERTAKER	**ADDRESS**
Henry W Jenkins & Son	Orchard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86996

CERTIFICATE OF DEATH.

90 D 86996

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 East North Ave ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Frances Copes

(a) RESIDENCE NO. 415 East North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred LIFE mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced [redacted] of (or) WIFE of George L. F. Copes

6 DATE OF BIRTH (month, day, and year) Sept. 29. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

037

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry C. Vickers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Ellen P Taylor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Rev. Thomas Copes
(Address) 415 East North Ave.

MAY 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1924, to May 14 1924, that I last saw h[er] alive on May 14 1924, and that death occurred, on the date stated above, at 9.20P m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis & Mitral Regurgitation (old age)

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of C

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) August Korn, M. D.

, 19 (Address) 40 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 5/17/24 19

20 UNDERTAKER H. E. Hughes

ADDRESS 424 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86997

CERTIFICATE OF DEATH.

145 D 86997

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 E. West St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LENA WINDHAM

(a) Residence No. 103 E. West St., Ward

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph E. Windham

6-DATE OF BIRTH (month, day and year) Nov. 26 1893

7-AGE,	If LESS than 1 day,
30 yrs. 5 mos. 18 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER John D. Thielbahr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Laura Dilks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

14-

(Informant) George H. McQuire

(Address) 103 E. West St.

15-

MAY 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10 1924, to May 14 1924, that I last saw him alive on May 14 1924, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia Dilatus

(Duration) — yrs. — mos. 15 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) A. Theilhaber, M. D.

, 19 (Address) 1320 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Cedar Hill Cem	May 17, 1924
20-UNDERTAKER,	ADDRESS
Joseph B. Cook	1803 N. Bath St

Spec—12-23-21—M.B.R.S.—400 Blks.

D 86998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 86998

CERTIFICATE OF DEATH.

49

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3530 Edmondson Avenue St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Gurney Golden Gilbert

(a) Residence No. 3530 Edmondson Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah I. Gilbert

6-DATE OF BIRTH (month, day and year) May 15, 1870

7-AGE,	If LESS than 1 day.
54 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk Balto
(b) General nature of Industry, business, or establishment in which employed (or employer): & Ohio Railroad
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Carroll County Maryland

PARENTS.

10-NAME OF FATHER, Thomas H. Gilbert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Margaret Clary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Mrs. Sarah I. Gilbert
(Address) 3530 Edmondson Ave.

15- Filed MAY 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1923 to May 15, 1924,
that I last saw him alive on May 15, 1924,
and that death occurred, on the date stated above, at 10.45 Am.

The CAUSE OF DEATH* was as follows:

Endothelioma of pleura with metastatic growth in rt temporal bone.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry D. McCarty, M. D.

5-15, 1924 (Address) 37 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Olivet Cem	May 17, 1924
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 N. Dallas St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 86999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 86999

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 120 South Schroeder St., 18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME SAMUEL HARDY

(a) Residence No. 120 S. Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Hardy

6-DATE OF BIRTH (month, day and year) Nov. 6"1837

7-AGE,	If LESS than 1 day,
86 yrs. 6 mos. 8 ds.	...hrs. or...min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Samuel Hardy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New York

14- (Informant) Mrs. Joseph P. Whalen

(Address) 120 S. Schroeder Street

15- Filed MAY 16 1924 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May, 14"1924

17- I HEREBY CERTIFY, That I attended deceased from May. 1, 19 24 to May. 14. 19 24.

that I last saw him alive on May 14. 19 24.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none.

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis etc.

(Signed) Thos. Corkran, M. D.

5/15/24 (Address) 888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
National Cemetery	May 17, 1924

20-UNDERTAKER,	ADDRESS
Joseph B. Cook	1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87000 — 161 — 9 — 87000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 E Gilling St 24 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Neal

(a) RESIDENCE. No. 429 E Gilling St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/13/24

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		2 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Bahlman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) as head 429 E Gilling St

15 Filed MAY 16 1924 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) — 5/16 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/13/24, 19..., to 5/16, 19 24, that I last saw h alive on 5/16, 19 24, and that death occurred, on the date stated above, at 8.430 m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 6/ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Wheeler M. D.

5/16, 1924 (Address) 1279 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem Co.	5-16 1924
20 UNDERTAKER	ADDRESS
Ehrs Hasle	115 E Mont St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87001

CERTIFICATE OF DEATH.

131 D 87001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Stubbs

(a) RESIDENCE. No. 1707 Mosher St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Floyd Samuels

11 BIRTHPLACE OF FATHER (city or town) S Carolina (State or country)

12 MAIDEN NAME OF MOTHER Alice Pool

13 BIRTHPLACE OF MOTHER (city or town) S. Carolina (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed MAY 16 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-9, 1924, to 5-15, 1924, that I last saw her alive on 5-14, 1924, and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pyelitis
Septicemia (B. Coli)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Lab. & Autopsy

What test confirmed diagnosis?

(Signed) Claude S. Bruce, M. D.

5-15 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Florence S. C.	5-16 1924
20 UNDERTAKER	ADDRESS
Daniel Taylor	Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87002

CERTIFICATE OF DEATH.

99-00

1-PLACE OF DEATH

City of BALTIMORE (No. 730 Bradley St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Thomas

(a) Residence No. 730 Bradley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1867

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or, min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, Lewis Holmes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Eliza Washington

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Nancy Scott

(Address) 730 Bradley St

MAY 16 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 26 1927 to May 15 1924

that I last saw h[illegible] alive on May 14 1924

and that death occurred, on the date stated above, at 10 20 9 m.

The CAUSE OF DEATH* was as follows:

a Cute Bronchitis

(Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. Bauer, M. D.

, 19 (Address) 1527 Jacobs

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	5-17, 19 24
20-UNDERTAKER	ADDRESS
Daniel Carter	916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87003

CERTIFICATE OF DEATH.

161-001 D 87003

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Colfer

(a) Residence No. 333 N. 21st St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-15-1924

7-AGE, Infant yrs. mos. ds. If LESS than 1 day, 5 hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Colfer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do not know

12-MAIDEN NAME OF MOTHER, Ethel Colburn Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Cumberland Md Do not know

11- (Informant) Mrs Wm Colfer

(Address) 333 N. 21st St City

15- MAY 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-15-1924

17- I HEREBY CERTIFY, That I attended deceased from 5-14- 1924 to 5-15- 1924

that I last saw h alive on 5-15- 1924

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. 5 hrs. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Harper M. D

, 19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	5-15- 1924
20-UNDERTAKER.	ADDRESS
H. C. Brauning Son	517 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87004 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 87004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 13 WARD)

2-FULL NAME Jennie R. Carnes

(a) RESIDENCE No. 3509 Elm Ave ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Femal	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer ? Oil

(b) General nature of industry, business, or establishment in which employed (or employer) W. Frew. Woodbury Mills Inc

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph R Carnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A Enson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. L. V. Burns

(Address) 3509 Elm Ave

15 Filed MAY 16 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to May 15, 1924, that I last saw her alive on May 15, 1924, and that death occurred, on the date stated above, at 9:53 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Donald Chandler, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL May 17 1924

20 UNDERTAKER Horace F. Burgee — ADDRESS 363 Fallsland

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-007

118 D 87005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 E Gittings ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Franklin Brown

(a) RESIDENCE. No. 523 Gittings ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At school

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Chas W Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Susie E Snader

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Chas W Brown
(Address): 523 E Gittings

15 Filed MAY 16 1924, 19.... Robert A. Krauth, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17

I HEREBY CERTIFY, That I attended deceased from May 15 1924 to May 15 1924,

that I last saw him alive on May 15 1924,

and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Acute intestinal obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys

(Signed) Thos E Shuler, M. D.

5/15, 1924 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: 5/17/1924

20 UNDERTAKER: E J Deming & Son — ADDRESS: 1938 E Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87006

CERTIFICATE OF DEATH.

185 D 87006

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 Hopkins Place ST., 19 WARD)

2-FULL NAME David J. Thomas Jr.

(a) RESIDENCE NO. 504 N Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 29-1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: David Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Mollie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Philadelphia

14 Informant (Address): Mollie Brown 504 N Stricker

15 Filed ....., 192.. ROBERT R. KRAUTER, Registrar
MAY 16 1924
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull —

(duration) ... yrs. 6 hrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fell from Ladder while at work

(duration) ... yrs. 1 mos. ... ds.

(Signed) H K Gorsuch, M. D.
(Coroner.)

5-14, 1924 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md May

DATE OF BURIAL: 16 1924

20 UNDERTAKER: H. Howard Evans 38

ADDRESS: E. Ford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87007

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 Colvin ST.; 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Stokes

(a) RESIDENCE. NO. 535 Colvin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Child)

6 DATE OF BIRTH (month, day, and year) Mar 10-1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Moses Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Strasburg Va

12 MAIDEN NAME OF MOTHER Alice Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Strasburg Va

14 Informant (Address) Annie Brooks 535 Colvin St

15 [illegible] MAY 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1924 to May 13, 1924

that I last saw her alive on May 12 th, 1924

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatism.

(duration) yrs. 3 mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) — yrs. one mos. — ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leuk, M. D.

May 14 (Address) With Bo & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	17 May 1924
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87008

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001 ✓ D 87008

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1244 Hargest Lane St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta - D. Smoot

(a) Residence No. 1244 Hargest Lane St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4f yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John W Smoot

6-DATE OF BIRTH (month, day and year) Nov. 4/860

7-AGE. 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). Balt. Md

PARENTS.

10-NAME OF FATHER. Fredrick DeRuff

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sarah Fauber

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balt Md

14-

(Informant) William DeRuff

(Address) 1244 Hargest Lane

15-

MAY 16 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 14. 24

17- I HEREBY CERTIFY, That I attended deceased from April 28 1924 to date of death

that I last saw h.. alive on date of death

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Due to pernicious Anemia of indefinite duration Cardiac Dilatation a few days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O Wilkins LeDantec M. D

, 19 (Address) 824 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St John Cemetery. DATE OF BURIAL. May. 16. 1924

20-UNDERTAKER. Geo. J. Ruth. ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87009

90 D 87009

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 149 Montebello Terrace ST., 27 WARD)

2-FULL NAME William Schaub

(a) RESIDENCE NO. 149 Montebello Ter. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie F. Schaub

6 DATE OF BIRTH (month, day, and year) Aug. 10. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Imigration Dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Jennie F. Schaub

(Address) 149 Montebello Terrace

15 MAY 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 - 19 24

17 I HEREBY CERTIFY, That I attended deceased from May 1, 19 24, to May 15, 19 24.

that I last saw h. alive on May 14, 19 24.

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

Auricular fibrillation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clarence Jones, M. D.

5/15, 19 24 (Address) 4 W. Hamilton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/17 19 24
20 UNDERTAKER Kirkler & Kirkler	ADDRESS 1739 Eager

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87010

CERTIFICATE OF DEATH.

17 D 87010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., 76 WARD)

2-FULL NAME Geo J Senger,

(a) RESIDENCE: (Usual place of abode) No 3323 Eastern ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? 56 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fredericka A. Senger

6 DATE OF BIRTH (month, day, and year) June 14, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 013
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not given

12 MAIDEN NAME OF MOTHER Not given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not given

14 Informant Henry L. Senger
(Address) 1012 S. Eastern Ave

15 Filed MAY 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Suicide death on the day stated above.

The CAUSE OF DEATH* was as follows: Cut Throat

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo Chester Bolden, M. D.
(Coroner.)

5/16/24, 192 (Address) 1716 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL 5/17 1924

20 UNDERTAKER Perkins & Perkins

ADDRESS 1734 Eager

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87011

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William W. King

(a) RESIDENCE No. 2105 E. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed MAY 16 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk!

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15-1924

17

I HEREBY CERTIFY, That I attended deceased from 5-10, 1924 to 5-15, 1924

that I last saw h~~e~~alive on 5-15, 1924

and that death occurred, on the date stated above, at 9:40 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Myocarditis
Myocardial Insufficiency

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sx

(Signed) Claude T. Dreen M. D.

5-15-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 5/16 1924

20 UNDERTAKER J. F. Oakley Stone

ADDRESS 316 E. Lafayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87912 87912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 E. Lombard. ST.: No 100 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine F. Stohlman

(a) RESIDENCE. No. 330 E. Lombard St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 10-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Fredrick Stohlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. city.

12 MAIDEN NAME OF MOTHER Catherine Rotschmeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Fredrick Stohlman (Address) 330 E. Lombard St.

15 Filed MAY 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-28-24, 19..., to 5-15-24, 19..., that I last saw h[illegible] alive on 5-15-24, 19..., and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Emphysema.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. J. Herrman M. D.

19 (Address) 729 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 17 1924
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

MAY 16 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87013

CERTIFICATE OF DEATH.

15 43

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3018 w North Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vivian Jeanette C Rosenberg

(a) Residence No. 3018 W North Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) August 11 1905

7-AGE, 18 yrs. 9 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Annapolis Md

PARENTS

10-NAME OF FATHER, Samuel Rosenberg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Hortance Lang

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- Jack Lewis (Informant)

1439 E Baltimore St (Address)

15- Filed MAY 16 1924 Robert P. Garrison Registrar.

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14 - 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 15 "....., 1924 to May 14th 1924

that I last saw h.e alive on May 14th 1924

and that death occurred, on the date stated above, at 5 40 p.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of jaw and tongue

(Duration) yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 3 operations by Dr Mc Fee

Was there an autopsy? no

What test confirmed diagnosis? Pathological + autopsy

(Signed) Herbert E. Sobel M. D

May 16 1924 (Address) 3018 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem — DATE OF BURIAL, 5/18 1924

20-UNDERTAKER, Jack Lewis 1439 E Balt St — ADDRESS

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87014

CERTIFICATE OF DEATH.

90 D 87014

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital - ST., 27 WARD)

2-FULL NAME Geo W Zeigler

(a) RESIDENCE (No. 204 W. Maple Ave ST., ... WARD .....)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary L Zeigler

6 DATE OF BIRTH (month, day, and year) Nov. 24th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Policeman 8/1
(c) Name of employer Balto P. Dept.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Andrew L Zeigler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Dorothy Haag

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Catherine L Zeigler
(Address) 204 W. Maple Ave

15 Filed MAY 16 1924 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

3 Months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

(Signed) Geo E Blacklock, M. D.
(Coroner)

5/15/24 192 (Address) 143 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemy — DATE OF BURIAL May 17th 1924

20 UNDERTAKER Tilly & Zeiler — ADDRESS 1038 S. Woodyard

Burial Permit Clerk

* WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 37015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1630 Linden Ave St., 14 Ward) 100

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Lacy.

(a) Residence No. 1630 Linden Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Whitaker Lacy

6-DATE OF BIRTH (month, day and year) Mch 5 1840

7-AGE. 84 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). N. Y.

PARENTS.

10-NAME OF FATHER. Robert Lacy

11-BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12-MAIDEN NAME OF MOTHER. Lucy White

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

14- (Informant) Robert J. Lacy
(Address) 1630 Linden Ave

15- Filed MAY 15 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 12 1924 to May 15 1924 that I last saw h. alive on May 14 1924 and that death occurred, on the date stated above, at 12.00 m.

The CAUSE OF DEATH* was as follows:

Pneumonia-Bronchus.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C. Clarke M. D.

May 16 1924 (Address) Lafayette Court Med Dr

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. May 17, 1924

20-UNDERTAKER. John A. Mitchell ADDRESS 1201 W Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87016

CERTIFICATE OF DEATH.

45 D 87016

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2227 Oak ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ellen A. Gilbert

(a) RESIDENCE No. 2227 Oak ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Coleman Gilbert

6 DATE OF BIRTH (month, day, and year) Jan 15-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William March

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Stiltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Coleman Gilbert (Address) 2227 Oak St.

15 Filed ..... 19 ..... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1924, to May 16, 1924, that I last saw h[illegible] alive on May 15, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid & rectum

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes. Date of Sept-1922

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Homer C. Todd, M. D.

5/16, 1924 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnsville Cemetery	May 17, 1924
20 UNDERTAKER Robt. Emmert Dietz	ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entries on other side of form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87017

CERTIFICATE OF DEATH.

90 D 87017

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 N. Bond ST., 8 WARD)

2-FULL NAME Hannah Elizabeth Parker

(a) RESIDENCE NO. 1305 N Bond ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Hugh J Parker

6 DATE OF BIRTH (month, day, and year) Jan 20th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Edward W. Pryor

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Annette Mentzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Miss Helen A Parker (Address) 1305 N. Bond St

15 Robert P. Harrison, Registrar

MAY 16 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1927

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1927, to May 16, 1927, that I last saw h.. alive on May 16, 1927, and that death occurred, on the date stated above, at 5.15 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Compensation

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J Wade Thomas, M. D.

(Address) 1228 E Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 18th 1927

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87018

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87018

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2016 E. Baltimore St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... John M. Bennet

(a) Residence No.. 2016 E. Baltimore St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr 18-1848

7-AGE, ...76.... yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired 845

(b) General nature of industry, business, or establishment in which employed (or employer)..... Coal Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Bennet

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Harriett B. Bennet

(Address) 2016 E. Baltimore St.

15- Filed MAY 16 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5/14/24

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1924, to May 14, 1924, that I last saw h.. alive on May 14, 1924, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Colon

Cardiac Dilatation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Manuel S. Herbert, M. D.

, 1924 (Address) 3325 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pleasant View Cemetery	May 17th 1924
20-UNDERTAKER. J. A. Moran	ADDRESS 300 E. Baltimore

B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

MAY 16 1924

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87019

D 87019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Morrell Park / 31

CITY OF BALTIMORE: (No. Thirteenth ST.: 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Katchukis

(a) RESIDENCE. NO. Thirteenth Morrell Park ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Tailoress / Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sonneborn & Sons Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Katchukis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Caroline Stasiunas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Caroline Katchukis
(Address) Thirteenth St

15 Filed MAY 16 1924 Robert P. Harrison, Registrar

Burial Permit Work

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1924 to May 16 1924

that I last saw her alive on May 15 1924

and that death occurred, on the date stated above, at 10:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brokuskas, M. D.

5-16 1924 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	May 20 1924
20 UNDERTAKER Chas B. Kuckuskas	ADDRESS 637 S. Paca St.

MAY 16 1924

—THIS IS A ... PLAINLY, WITH UNFADING INK—The information should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87020 168 D-87020

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 So. Addison ST. 19 WARD)

2-FULL NAME George Parr

(a) RESIDENCE NO 102 So. Addison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Parr

6 DATE OF BIRTH (month, day, and year) May 12th 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	—	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R R 073

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Darr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amanda Parr
(Address) 102 So. Addison St

15 Filed MAY 16 1924, 192 Robert P. Garrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Hanging
Strangulation (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Norton, M. D.
(Coroner.)
May 15, 192 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL May 19 1924

20 UNDERTAKER George L. Schwab — ADDRESS Curtis Bay, Md.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may ... may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87021

D 87021

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

City of BALTIMORE: (No. 123 E. Eden St., 24 Ward) 100-00

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse C. Kirby

(a) Residence No. ~~2942~~ 123 E. Eden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Balto yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed,~~ or ~~Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Estella Kirby

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Kirby

11-BIRTHPLACE OF FATHER (city or ~~town~~), Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth Hooper

13-BIRTHPLACE OF MOTHER (city or ~~town~~), Balto (State or Country), Md.

14- (Informant) Bay View Hospital

(Address) Balto., Md.

15- Dec. 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAY 16 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/15/24

17- I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 15, 1924, that I last saw him alive on May 15, 1924, and that death occurred, on the date stated above, at 12.35 P. m.

The CAUSE OF DEATH* was as follows:

Luminal Bronchopneumonia

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis and Deterioration

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. J. Bodmett M. D.

5/15, 1924 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, May 19 1924

20-UNDERTAKER Fred M. Tisdale Son

ADDRESS 811 N. Wolfe St.

MARGIN RESERVED FOR BINDING.

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87022

HEALTH DEPARTMENT—CITY OF BALTIMORE

74.001 ✓ D 87022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE, (No. 1606 Madison Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Muncaster

(a) Residence No. 1606 Madison Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1873

7-AGE, 51 yrs. 1 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Raysford Co Md.
(State or Country).....

PARENTS.
10-NAME OF FATHER, Lusby B Muncaster
11-BIRTHPLACE OF FATHER (city or town)..... Raysford, Co Md.
(State or Country).....
12-MAIDEN NAME OF MOTHER, Isabel Allen
13-BIRTHPLACE OF MOTHER (city or town)..... Raysford Co Md.
(State or Country).....

14-
(Informant)..... Walter F Muncaster
(Address)..... 1606 Madison Ave

15-
Filed..... 192..... Robert E. Harrison, Registrar.

MAY 16 1924
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 14-24

17- I HEREBY CERTIFY, That I attended deceased from Mch 15 19 24 to May 14 19 24
that I last saw h.r alive on May 14 19 24
and that death occurred, on the date stated above, at 330 P m.
The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
and Colic adenoma of
thyroid
(Duration) ubknown hrs. ds.
CONTRIBUTORY (Secondary) Apoplexy
(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward M. D.
, 19 (Address) 2256 Mosman Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Elkwood Md. DATE OF BURIAL. May 17 19 24

20-UNDERTAKER. Martin Lakey & Son ADDRESS 1870 North Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87023

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 76 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Schmidt

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Basket Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Dietus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records (Address)

15 Received MAY 16 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 12-13, 1922, to 5-16, 1924, that I last saw him alive on 5-15, 1924, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Draper M. D.

5-16 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 17 1924
20 UNDERTAKER	ADDRESS
Henry Hauck Son	1301 E Eager St

MARGIN RESERVED FOR BINDING

B—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87024

CERTIFICATE OF DEATH.

91 D 87024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park View Sanitorium ST., Greenspring Ave 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L. M. French

(a) RESIDENCE NO. Park View Sanitorium ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E M French

6 DATE OF BIRTH (month, day, and year) Oct 1st 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastport (State or country) Maine

PARENTS

10 NAME OF FATHER Robt Howe

11 BIRTHPLACE OF FATHER (city or town) Eastport (State or country) Maine

12 MAIDEN NAME OF MOTHER Phoebe A Reazey

13 BIRTHPLACE OF MOTHER (city or town) Eastport (State or country) Maine

14 Informant Mrs Margaret M. Wanstall (Address) 606 Bolton St

15 Filed MAY 16 1924 19 Robert F. Carrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1924, to May 16, 1924, that I last saw h[illegible] alive on May 15, 1924, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis -

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Malnutrition - 6 mos.

Small denomia (duration) 2 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Austin T. Robinson M. D.

5/16 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL May 17 1924

20 UNDERTAKER Henry H. Jenkins Sons — ADDRESS Orchard & Gilmor

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87025

X 90 D 87025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank, L. Lindsay

(a) RESIDENCE No 717 N Calvert ST., ... WARD Union Bridge Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Alice Lindsay

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	-		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER F Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland.

12 MAIDEN NAME OF MOTHER Nel Kinrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Florida

14 Informant Robt M. Lindsay
(Address) 711 Lemmon ave.

15 Filed MAY 16 1924 192 Robert F. Carrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Broken Comp

(Duration) yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Rhodes, M. D.
(Coroner)

5/16/24, 192 (Address) 443 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Union Bridge Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge Md

DATE OF BURIAL 192

20 UNDERTAKER W. M. Coulson

ADDRESS 2228 W. North Ave

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificate.

MAY 16 1924

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87026

161-001

D 87026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Imbadore Green ST., 19 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Morrison

(a) RESIDENCE No. 2624 Hampden St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ira Morrison

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary LeDoyen

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa

14 Informant Univ Hosp records
(Address)

15 MAY 7 1924 Robert F. Harrison
19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 10, 1924, that I last saw him alive on May 16, 1924, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....

.....

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) David R. Newman M. D.

May 16 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 17 1924
20 UNDERTAKER	ADDRESS
Lepenwell & Son	3613 Chestnut Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87027

CERTIFICATE OF DEATH.

90 D 87027

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital (St., 16 Ward)

2-FULL NAME Frances Smith

(a) RESIDENCE No. 2826 Winchester St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Ireland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Winifred Conyers

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mercy Hospital
(Address)

15 MAY 17 1924 Robert P. Harrison, ..., 19 .....
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/24

17 I HEREBY CERTIFY, That I attended deceased from 5/3/24, 19....., to 5/16/24, 19.....,
that I last saw h[illegible] alive on 5/16/24 19.....
and that death occurred, on the date stated above, at 2.10 p. m.
The CAUSE OF DEATH* was as follows:

Myocarditis
Mitral Insufficiency
Acute Dilatation

(duration) 12 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. W. Bolley, M. D.
, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/17/24
20 UNDERTAKER Edgar A. Finley	ADDRESS Fayette

Cor.—1-12-23—M&T—100 Bks.

Hare

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87028

CERTIFICATE OF DEATH.

1824 D 87028

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1849 Horton, Fort Lowell St., ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton O. Hare

(a) RESIDENCE No. 1849 N. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Retired

6 DATE OF BIRTH (month, day, and year) July 15 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm H Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Hersh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Estela Hare
(Address) 1949 Castle St

15 Filed MAY 17 1924, 192 Robert F. Garrison Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. ds.

(Signed) Jno. C. Blades, M. D.
(Coroner.)

5/16/24, 192 (Address) 143 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 1924

20 UNDERTAKER Chenowith & Son ADDRESS 3617 Chestnut Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

(Daniel Jones)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87029

CERTIFICATE OF DEATH.

202 D 87029

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 7 WARD)

2-FULL NAME Daniel Jones.

(a) RESIDENCE NO 903 Ruttis St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~ ~~Widowed~~, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt 36				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed MAY 17 1924, 192 Robert P. Garrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

5/16/24 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pat Auburn	May 17 1924
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87030

CERTIFICATE OF DEATH.

146 D 87030

1-PLACE OF DEATH South Balto Gen Hosp

CITY OF BALTIMORE: (No. Light St near 22nd) (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret G Rand

(a) RESIDENCE No. 213 W 25th St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Rand

6 DATE OF BIRTH (month, day, and year) Dec 5. 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Rand
(Address) 713 W. 25th St

15 Filed ..... Robert P. Garrison, Registrar

MAY 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/15 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 1924, to 5/15, 1924, that I last saw her alive on 5/15, 1924, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy
Expulsive Labor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Holtzman M. D.

. 19 (Address) 1629 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	May 19 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E Fath Ave

Cor.—1-12-23—M&T—100 Bks.

D 87031

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87031

CERTIFICATE OF DEATH.

165 Greenmount Ave

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE (No. Rear North side of Melrose ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roger Chandler Knipp

(a) RESIDENCE No 3820 Ashburton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 0 mos. 16 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Knipp

6 DATE OF BIRTH (month, day, and year) April 26, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	0	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Furniture Buyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Jno C. Knipp & Sons 845 Balto.

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas C Knipp

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary S Chandler

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mrs. Dorothy Knipp
(Address) 3820 Ashburton Ave

15 Filed MAY 1 7 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Acid Poison
(Suicide)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison, M. D.
(Coroner.)

May 16 1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 17 1924
20 UNDERTAKER Wm Fickner & Sons	ADDRESS North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 87032

1-PLACE OF DEATH

City of BALTIMORE: (No. 5216 Palmer Ave St. 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ralph Patterson

(a) Residence No. 5216 Palmer Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept 14-1898

7-AGE. 25 yrs. 8 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer). 009
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Howard McPatterson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Anna Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Anna Patterson
(Address) 5216 Palmer Ave

15- Filed MAY 16 1924 Robert E. Garrison, Registrar.

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 15-24

17- I HEREBY CERTIFY, That I attended deceased from May 11 1924 to May 15 1924

that I last saw him alive on May 15 1924

and that death occurred, on the date stated above, at 8.30a.m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Robert Drummond

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Chas J Wells M. D

. 19 (Address) 2 W Biddle Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine	..... 19 ...
20-UNDERTAKER. P E Cochran Sons	ADDRESS. Baltimore

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

435 87033

1-PLACE OF DEATH

City of BALTIMORE: (No. 1805 Seamuitt St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Benj Franck

(a) Residence No. 1805 Seamuitt St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Franck

6-DATE OF BIRTH (month, day and year) Feb. ? 1875

7-AGE. 48 yrs. 2 mos. ? ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Mr. Harry Franck

(Address) 1805 Seamuitt St

15- Filed Robert P. Harrison, Registrar.

MAY 17 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 15 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15 19 22 to March 19 24

that I last saw him alive on May 14 19 24

and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Palate

(Duration) yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Cancer of Colon

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Williams M. D.

May 17, 1924 (Address) 1 E Franklin

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Hampton Lawn — DATE OF BURIAL, May 19 1924

20-UNDERTAKER, Wm Hickey — ADDRESS North Ave

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87034 HEALTH DEPARTMENT—CITY OF BALTIMORE. X 188 D001 87034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Hill

(a) RESIDENCE NO. 716 S Sr. ST., WARD Sparrows Point Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colred	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co,
(c) Name of employer 040

9 BIRTHPLACE (city or town) Va,
(State or country)

PARENTS

10 NAME OF FATHER Troy Hill

11 BIRTHPLACE OF FATHER (city or town) Va,
(State or country)

12 MAIDEN NAME OF MOTHER Mahanna,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas. Davis
(Address) 716 E. S. Sparrows Point Md.

15 Filed ..... 192 Robert P. Harrison, Registrar

MAY 17 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jur (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

R. R. accident.
(Cancel between lines)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage + shock,

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 16, 1924 (Address) 2502 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Sparrows Pt. Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. White Plains Cem	May 17 1924
20 UNDERTAKER Sam'l W. Chase Inc	ADDRESS 1480 Mosher

CAUTION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—

Cor.—1-12-23—M&T—100 Bks.

D 87035

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 87035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1742 E Lombard ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert J Byrnes,

(a) RESIDENCE No. 1742 E Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 18, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Karl Byrnes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Catherine Dingmore

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Karl Byrnes
(Address) 1742 E Lombard St

15 Filed ..... 192 Robert F. Harrison,
Registrar

MAY 17 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

(Signed) Jno C. Wade, M. D.
(Coroner.)

5/17/24 192 (Address) 143 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patricks Cemetery	May 17 1924
20 UNDERTAKER	ADDRESS
H. Sonder Sons	1710 Eut St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87036

CERTIFICATE OF DEATH.

D 87036

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1411 Amoshury St.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Floyd

(Residence in Baltimore: No. 1411 Amoshury St.; 38 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Married

6-DATE OF BIRTH, 4 Sept (Month) (Day) 1876 (Year)

7-AGE, 47 yrs. ..... mos. ..... da. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Oil

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Floyd

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy Floyd, Wife

(Address) 1411 Amoshury

15- Filed ....., 191.....

Robert F. Harrison, Registrar.

MAY 17 1924

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1924 to May 16 1924, that I saw h.. alive on May 15 1924 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) ..... yrs. 1 mos. 14 da.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. 1 mos. 14 da.

(Signed) Charles H. Fiore M. D.

May 16 1924 (Address) 712 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bush Burial cemetery — DATE OF BURIAL, May 18, 1924

20-UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUALIFICATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87037

CERTIFICATE OF DEATH.

100-0 D 87037

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Ware

(a) RESIDENCE. NO. 1811 McCullough ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Music Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wm Ware

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lynchburg Va.

12 MAIDEN NAME OF MOTHER Fannie Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Municipal Hospital Reports

15 Filed MAY 17 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-15-1924

17

I HEREBY CERTIFY, That I attended deceased from 5-13 . 1924 to 5-15 . 1924

that I last saw her alive on 5-15 . 1924

and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Pneumococcus Septicaemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sat. + Autopsy

(Signed) Claude G. Horsey, M. D.

5-14 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemty	5/18/1924

20 UNDERTAKER Helen A. Holland ADDRESS 1631 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87038

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1832 Walbrook ave ST., 15 WARD)

2-FULL NAME Emma Lavinia Hohenberger

(a) RESIDENCE No 1832 Walbrook ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? 21 yrs. 10 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Mnfgr

(c) Name of employer Heilbman Bros

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Hohenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lavinia Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Hohenberger
(Address) 1832 Walbrook ave

15 Filed ..... 19 ..... Robert P. Garrison, Registrar

MAY 17 1924

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1924, to May 16, 1924, that I last saw her alive on May 14th, 1924, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Health Dept.

(Signed) Leonard E. Beach, M. D.

, 19 (Address) 2231 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 19 1924
20 UNDERTAKER	ADDRESS 1944
Harry W. Ehlen	W. North ave

Cor.—1-12-28—M&T—100 Blks.

1924
85
1839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87039

CERTIFICATE OF DEATH.

D 87039

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2008 St Paul ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sara Louise Lyon

(a) RESIDENCE NO. 2008 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced (write the word)~~
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	85			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. J.
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mrs Frey C. Russhead
(Address) 601 Rosemont Ave Govans

15 Filed MAY 17 1924 Robert P. Harrison Registrar
Robert P. Harrison
Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Galveston
Pneumonia
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Monroe, M. D.
(Coroner.)
May 16, 1924 (Address) 2032 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	May 17, 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 1

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87040

CERTIFICATE OF DEATH.

100 D 87040

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Penal Home & Infirmary ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Stevenson Matthews

(a) RESIDENCE No. 2201 N Calvert ST., 12 WARD Resident

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 81 yrs. 7 mos. 18 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) Sept-28-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Amos Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Ellen Mash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Md.

14 Informant Mr. Lou Booth (nephew)

(Address) 703-E-22-St-City.

15 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to May 16, 1924.

that I last saw her alive on May 16, 1924,

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Capt Parker Matthews M. D.

, 19 (Address) Penal Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 19 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODLE, Successor)

ADDRESS 108 W. NORTH AVE

Burial Permit Clerk

Spec—12-23-21—B.B.N.S.—400 Blks.

D 87041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 87041

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3302 Eastern ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna G. Herda

(a) Residence No. 3302 Eastern ave St., 26 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Herman E. Herda

6-DATE OF BIRTH (month, day and year) Oct. 27th 1873

7-AGE. 50 yrs. 6 mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) House-wife

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Albert W. Nietsche

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Grebb

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Herman E. Herda

(Address) 3302 Eastern ave

15- Filed MAY 1 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15th 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1921 to May 15 1924

that I last saw h[illegible] alive on May 14 1924

and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urine + Blood Pressure.

(Signed) Frank A. Heintz, M. D

May 16 1924 (Address) 3204 Eastern ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood Cemetery — DATE OF BURIAL, May 18th 1924

20-UNDERTAKER, Lilly & Zeibel — ADDRESS 4033 Wash Av.

Burial Permit Work.

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS FOR PERMANENT RECORD. instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 87042

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87042

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 W. North Ave. ST., 15 WARD)

2-FULL NAME Abraham Jones

(a) RESIDENCE NO. 1705 W. North Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Jones

6 DATE OF BIRTH (month, day, and year) Jany. 23, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shoe

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant. 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Wolf Jones

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Schulman

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mr. Jones (Address) 1705 W. North Ave.

15 Robert P. Garrison, Registrar

MAY 17 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/ 1924

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1924, to May 17, 1924.

that I last saw him alive on May 16, 1924

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? By Symptoms & Signs.

(Signed) C. Weinstock, M. D.

(Address) 57 Pontiac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	5/19/1924
20 UNDERTAKER David Londheim	ADDRESS 117-20 W. Mt. Royal Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87043 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87043

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1214 Brentwood Ave St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Viola M Schussler

(a) Residence No..... 1214 Brentwood Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edw A Schussler

6-DATE OF BIRTH (month, day and year) Aug 14 188[illegible]

7-AGE 42 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Jno J. Dressell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Anna J. Sheffer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant) Edw A Schussler

(Address) 1214 Brentwood Ave

Robert F. Duffy

15- Filed ..... 19[illegible] Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15 1924

17- I HEREBY CERTIFY, That I attended deceased from May 9th, 1924, to May 15th 1924

that I last saw h. alive on May 15th 1924

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urine analysis

(Signed) Howard A Lyon M. D.

, 19 (Address) 530 E. Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood — DATE OF BURIAL, May 19 1924

20-UNDERTAKER, W. C. Wiedefeld — ADDRESS 9 N Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87044

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Weston

(a) Residence No. Bay View Asylum St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885

7-AGE,	If LESS than 1 day,
37 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&O

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS:

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

11- (Informant) Municipal Hospital Records

(Address) .....

15- Filed ..... Robert P. Harrison, Registrar.

MAY 1 / 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-13-24

17- I HEREBY CERTIFY, That I attended deceased from 5-8, 1924 to 5-13, 1924

that I last saw he alive on 5-13, 1924

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Jones, M. D.

5-13, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
20-UNDERTAKER,	ADDRESS

UNIVERSITY OF MARYLAND

NO. 8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87045

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 87045

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4017 Ridgewood Ave St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry F. New

(a) Residence No. 4017 Ridgewood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apr. 21 - 1855

7-AGE, 69 yrs. mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Griffith & Turner Co

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Peter New

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Regina Kustner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Lonie New

(Address) 4017 Ridgewood Ave

15- Filed Robert P. Harrison Registrar.

MAY 17 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16 - 24

17- I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1924, to May 16, 1924, that I last saw h[illegible] alive on May 16, 1924, and that death occurred, on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hacmoglobinuria (Negro)

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jesse C. Clark M. D.

May 17, 1924 (Address) 2 Aisquith and Read Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park Cem	May 17, 1924
20-UNDERTAKER.	ADDRESS
Geo. J. Smith	1532 Hollins St

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Welly

D 87046

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87046

CERTIFICATE OF DEATH.

X 43

1-PLACE OF DEATH

City of BALTIMORE. (No. St. Agnes Hospital 25 St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr Norman Welty

(a) Residence No. Emmitsburg Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR ~~RACE~~. White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Mrs Mary Welty

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (City or town) (State or Country). Not Known

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (City or town) (State or Country). Not Known

11-(Informant) Mrs Mary Welty

(Address) Emmitsburg Md

MAY 18 1924

Filed 192 GUEST R. KRAUTER.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17 24

17- I HEREBY CERTIFY, That I attended deceased from May 15 19 24 to May 17 19 24

that I last saw h. alive on May 17 19 24

and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was an follows:

Peritonitis (Colon Bacillus

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma Coecum

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of 5/16/24

Was there an autopsy?

What test confirmed diagnosis? Path Exam

(Signed) H O Harper, M. D

19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Emmitsburg Md.	May 18, 1924
20-UNDERTAKER.	ADDRESS
Chas. G. Black	742 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87047

101-09 87047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 443 w Henrietta ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cephus Wallace

(a) RESIDENCE NO. 443 W Henrietta ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb, 2d, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 0'4

(c) Name of employer ?

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Maryland.

PARENTS

10 NAME OF FATHER Wesham Wallace

11 BIRTHPLACE OF FATHER (city or town) Calvert Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie Carr

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co. (State or country) Maryland.

14 Informant Annie Wallace (Address) 443 w Henrietta

15 Filed MAY 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 3, 1924, to May, 16, 1924,

that I last saw him alive on May, 15, 1924,

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Wm Franklin, M. D.

5/16, 1924 (Address) 125 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkers Creek Calvert Co Md	May 18 1924
20 UNDERTAKER	ADDRESS
J L V Brown & Son	108 N Monroe St

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87048

CERTIFICATE OF DEATH.

101-001

D 87048

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2804 Suffolk Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Fine

(a) Residence No. 2809 Suffolk Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Fine

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Woman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, don't know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Josh Louis

(Address) 1439 E Balto St

15- MAY 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-16-24

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924 to May 16 1924

that I last saw h[illegible] alive on May 16 1924

and that death occurred, on the date stated above, at 7 P M

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

Edema of Lung

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? At home

Dbl an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Joseph Eyeman M. D

19 (Address) 1516 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Herzendaathrop	5/18 1924
20-UNDERTAKER,	ADDRESS
Josh Louis	1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87049

CERTIFICATE OF DEATH.

D 87049

117

1-PLACE OF DEATH Hebrew Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument St. & Rutland Ave. WARD 7)

2-FULL NAME Louis Goldberg.

(a) RESIDENCE NO. 1704 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 14 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	30	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockmen

(b) General nature of industry, business, or establishment in which employed (or employer) Broker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER Philip Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/3, 1924, to 5/17, 1924,

that I last saw him alive on 5/17, 1924,

and that death occurred, on the date stated above, at 9:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute appendicitis with peritonitis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/15/24 5/14/24

(1) Appendectomy (2) Exploratory.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Sidney D. Levy, M. D.

May. 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave	5/18 1924

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87050 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87050

CERTIFICATE OF DEATH. X 74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 305 N. Bolfield St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Wrangus

(a) Residence No. 305 N. Bolfield St., Ward Cambridge Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, ~~Widowed~~ or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1855

7-AGE. 69 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): 10

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): Ky Mauz Co. Md

PARENTS.

10-NAME OF FATHER, Dan Hopkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER, Dinah Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Dan Brown

14- (Informant) Daniel Easton

(Address) 305 N. Bolfield St.

15- Filed MAY 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924, to May 17 1924, that I last saw her alive on May 16 1924 and that death occurred, on the date stated above, at 10:38 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. H. Coffin, M. D.

, 19 (Address) 15 Race St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md. — DATE OF BURIAL, 5-17-24

20-UNDERTAKER: David Easton — ADDRESS 6 Race

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87051

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 D 87051

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 N. Stricker St. 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irma Murray

(a) RESIDENCE No. 335 N Stricker St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feby. 1. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 000

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Grass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Andrew Murray

(Address) 335 N Stricker St

15 MAY 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12 1924 to May 16 1924

that I last saw her alive on May 16 1924

and that death occurred, on the date stated above, at 8.45 p m.

The CAUSE OF DEATH* was as follows:

Eclampsia - (Primary) (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Brueninger, M. D.

5/17/24 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-19 1924
20 UNDERTAKER	ADDRESS 916
David Easton	Penn

Spec.—1-10-21—M&T—1500 Bks.

D 87052

D 87052 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2635 W Franklin ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Leo O'Connor.

(a) RESIDENCE NO. 2635 W. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 6 mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	divorced

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Bertie Conn O'Connor

6 DATE OF BIRTH (month, day, and year) October 27-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work garbage cart driver

(b) General nature of industry, business, or establishment in which employed (or employer) City of Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catharine Murphy.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Catherine Joachim (Address) 2635 W. Franklin St.

15 Filed MAY 18 1924 ROBERT R. MAGISTRY, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16- 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1924 to May 16-, 1924.

that I last saw him alive on May 16-, 1924.

and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs

(Signed) Chester Ruland, M. D.

5-16, 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Dulaney Conn — DATE OF BURIAL 5-19 1924

20 UNDERTAKER David Carton — ADDRESS 916 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87053

CERTIFICATE OF DEATH.

90 D 87053

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. W. Adams

(a) RESIDENCE No 2256 Morris St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Works
(c) Name of employer J. E. Snyder

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Geo W Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Sarah Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Jennie Adams
(Address) 2256 Morris St.

MAY 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

(Signed) Geo. C. Radcliffe, M. D.
(Coroner)

5/16/24, 192 (Address) 943 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	5-18 192 4
20 UNDERTAKER David Easton	ADDRESS 916 Dc ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87054 | 129 | D 87054

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705-N-Carey ST., 16 WARD) Eastern

2-FULL NAME Elizabeth Rosenberg

(a) RESIDENCE NO. 705-N-Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Rosenberg

6 DATE OF BIRTH (month, day, and year) May 6 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Working at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Snow Hill Md

PARENTS

10 NAME OF FATHER George Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Snow Hill Md

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Snow Hill Md

14 Informant Sister Mrs. E. Lee

(Address) 712-N-Mount St

15 Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8 , 1924, to May 15 , 1924, that I last saw h alive on May 15 , 1924, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows: Mitral Insuf.

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home 9 days

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) Wm W J Jackson, M. D.

, 19 (Address) 1617 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-19-24
20 UNDERTAKER David Easton	ADDRESS 916 Pine

Spec.—1-10 21 M&T 1500 Blks.

Carrie M Sieck

87055

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓

12/4 D 87055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 11 Broadway ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sieck, Mrs Carrie M

(a) RESIDENCE No. 1116 Hanover Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick A. Sieck

6 DATE OF BIRTH (month, day, and year) Nov 25/1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home 137

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER James Edward Sexton

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Greenhawer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Carrie Sexton
(Address) 1116 Hanover St

15 MAY 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-5, 1924, to 5-16, 1924,

that I last saw h.. alive on 5-16, 1924,

and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis, interstitial

(duration) 3 yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Typical signs & symptoms at autopsy

(Signed) Henry C. P. Wilson Jr. M.D. M. D.

. 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	5/19/24
20 UNDERTAKER	ADDRESS
Geo. Weber Son	2503 Edmondson ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Rhea, 1211 N Patterson Park Ave
Plaza 65-15-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87056

CERTIFICATE OF DEATH.

164 D 87056

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3915 Roland Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia L Thompson

(a) Residence No. 3915 Roland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of H Asbury Thompson

6-DATE OF BIRTH (month, day and year) Sept 4. 1856

7-AGE. 87 yrs. 8 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Georgetown (State or Country), D C

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Georgetown (State or Country), D C

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Georgetown (State or Country), D C

14- (Informant) John L George

(Address) 3915 Roland Ave

15- MAY 18 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16. 1924

17- I HEREBY CERTIFY, That I attended deceased from April 14, 1924, to May 16, 1924, that I last saw her alive on May 16, 1924, and that death occurred, on the date stated above, at 4.50 G m.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Albert L Hesser M. D.

May 18 1924 (Address) 1211 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL, May 19, 1924

20-UNDERTAKER. Wm Cook ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.K.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87057

CERTIFICATE OF DEATH.

49 D 87057

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 West 25th St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Thomas Pyles

(a) Residence No. 118 West 25th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Blanche Pyles

6-DATE OF BIRTH (month, day and year) April 26, 1855

7-AGE. 69 yrs. 0 mos. 22 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City Jail

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Francis Pyles

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs. Blanche Pyles

(Address) 118 West 25th Street

15- Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 17. 24

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 23 to May 17 24

that I last saw h. alive on May 17 24

and that death occurred, on the date stated above, at 5.45 a m.

The CAUSE OF DEATH* was as follows:

E Francis Lake

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate and Bladder

(Duration) yrs. ? mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr. J. McCulloch

(Signed) E. Robinson M. D.

May 17. 1924 (Address) 112 W. 25th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Hampden — DATE OF BURIAL. 5/19 1924

20-UNDERTAKER, William Cook — ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87058 T 129 D 87058

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St Josephs Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dieter

(a) RESIDENCE NO. 3 Haveland Pk. Blvd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph A. Dieter

6 DATE OF BIRTH (month, day, and year) 2-2-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John H. Bierbrohb 3 Haveland Park

15 Filed MAY 18 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to May 16, 1924,

that I last saw he alive on May 16, 1924,

and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? B.P. & S.

(Signed) Harold C. Gillenwater M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	5-19 1924
20 UNDERTAKER Wm Cook	ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87059 | 3 | D 87059

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2119 Bunington Ave. Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria J. Martini

(a) Residence No. 2119 Bunington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Feby 18/1854

7-AGE: 70 yrs. 2 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Harford Co Md

PARENTS.

10-NAME OF FATHER: Robert Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Harford Co Md

12-MAIDEN NAME OF MOTHER: Susanna Seaman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Harford Co Md

14- (Informant) Annie J. Martini

(Address) 2119 Bunington Ave

15- MAY 18 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

Peoria 2105 N. Charles St

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 17/24

17- I HEREBY CERTIFY, That I attended deceased from Mar, 1924, to May 17, 1924, that I last saw h[illegible] alive on May 5, 1924, and that death occurred, on the date stated above, at 12.20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Jno. H. Pegues M. D.

, 19 (Address) 2105 N Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Harford Co — DATE OF BURIAL: May 19, 1924

20-UNDERTAKER: William Boyce & Son — ADDRESS: E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87060 ✓

D 87060

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 1169 Nanticoke St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary E Belcher

(a) Residence No.. 1169 Nanticoke St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of William E Belcher

6-DATE OF BIRTH (month, day and year) July 12 1856

7-AGE, 78 yrs. 10 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Barnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) William E Belcher

(Address) 1169 Nanticoke St

15-

Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar.

Dr. Brain Columbia Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 12/24

17- I HEREBY CERTIFY, That I attended deceased from 5/16, 19 24, to 5/12, 19 24

that I last saw h... alive on....., 19.....,

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Richard Dreaux, M. D.

, 19 (Address) 1122 Mt Pleasant Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cem | DATE OF BURIAL, May 20, 19 24

20-UNDERTAKER, William Bach | ADDRESS 502 E Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87061

CERTIFICATE OF DEATH.

D 87061

1-PLACE OF DEATH 1720 N. Port St

City of BALTIMORE: (No. 1720 N. Port St St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K Stocker

(a) Residence No. 1720 N Port St St., 8 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Henry Stocker

6-DATE OF BIRTH (month, day and year) Oct 31 1875

7-AGE. 48 yrs. 6 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER Mary Schmidt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mrs. K. Stocker

(Address) 729 Aisquith St

15- Filed MAY 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 8, 1924 to May 16, 1924, that I last saw h.r alive on May 16, 1924, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. 38 ds.

CONTRIBUTORY (Secondary) to my knowledge Pulmonary Tuberculosis

(Duration) yrs. mos. 38 ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) A. C. Macdonald, M. D.

May 16, 1924 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore DATE OF BURIAL, May 19, 1924

20-UNDERTAKER. W. Cook ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87062

CERTIFICATE OF DEATH.

44

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 2954 Greenwood St. NW Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas V. Botterill

(a) Residence No. 2954 Greenmount St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Botterill

6-DATE OF BIRTH (month, day and year) April 26-1861

7-AGE. 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Francis Botterill

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Susie Brooks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant) Le Roy M. Botterill

(Address) 2954 Greenmount

15-

Filed ROBERT R. KRAMER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 18-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 25, 19 23, to May 18, 19 24, that I last saw h[illegible] alive on May 17, 19 24, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Carcinoma (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) 4239 Gth Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Greenmount	May 21, 1924
20-UNDERTAKER,	ADDRESS
Wm S Cook	502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17076 Ind.

D 87063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 129 D 87063

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

2-FULL NAME Annie Wyatt

(a) RESIDENCE NO. 1 North Curley St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 15 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm F. Wyatt

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Barrett

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant .....
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed MAY 18 1924 . 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 19 24

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1924, to May 16, 1924,

that I last saw her alive on May 16, 1924,

and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Hypertension

Cerebral hemorrhage

(duration) 1 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 10 days

Pericarditis 8 days

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Study of blood and urine

(Signed) Jessie M. Kohn (Kohn) M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL May 21 1924

20 UNDERTAKER Lilly and Zeiler

ADDRESS 603 S. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

See affadivit on file May 31st 1924

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87064

CERTIFICATE OF DEATH.

129 D 87064

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3733 Fleet St. ST.: 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Greger. Jr.

(a) RESIDENCE. NO. 3733 Fleet St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Greger.

6 DATE OF BIRTH (month, day, and year) January 9-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe maker.

(b) General nature of Industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Greger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret. Greger (Wife)

(Address) 3733 Fleet St.

15 Filed . 19 ROBERT R. KRAUTER, Registrar

MAY 18 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/11/24, 19..., to 5/16, 19 24.

that I last saw him alive on 5/16/24, 19.....

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. E. McGarrell M. D.

19 (Address) 633-5-3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL May 19 1924

20 UNDERTAKER Lilly & Zeiler

ADDRESS 403 Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

287065

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 37065

287065

129

D 37065

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1847 N. Castle St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John E. Klein

(a) Residence No. 1847 N. Castle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Klein.

6-DATE OF BIRTH (month, day and year) Mar 19 1844

7-AGE. 80 yrs. 1 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)..... 188

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Carrie L. Klein

(Address) 1847 N. Castle

15- Filed MAY 18 1924 ROBERT R. KRAUTER, Burial Permit ~~Clerk~~.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 16 1924

17- I HEREBY CERTIFY, That I attended deceased from April 16th, 19..... to May 16, 1924

that I last saw him alive on May 16, 1924

and that death occurred, on the date stated above, at 6 25 m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis.

(Duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1847 N. Castle St

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Boyle, M. D.

, 19 (Address) 1900 Maryland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dulaney Cem — DATE OF BURIAL, May 18, 1924

20-UNDERTAKER, John Ellis & Son — ADDRESS 2008 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—E.B.R.S.—100 Blks.

D 87066

D 87066

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87066

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Jones

(a) Residence No. 508 pennsylvania ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Jones

6-DATE OF BIRTH (month, day and year) 1890

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: John Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Mary Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14- (Informant): Hospital Records

(Address): M.T.H.

Filed MAY 18 1924 193 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 9 19 24 to May 15 19 24,

that I last saw him alive on May 15 19 24,

and that death occurred, on the date stated above, at 12.40p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Labby M. D

5-15- 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Lebanon	May 17 19 26
20-UNDERTAKER.	ADDRESS
Co-Op Saml. J. Hemsley	1578 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87067

CERTIFICATE OF DEATH.

Bureau 90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Morgan Park Arlington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... James H. Arrington

(a) Residence No. Morgan Park St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Arrington

6-DATE OF BIRTH (month, day and year) Age Not Known

7-AGE.	If LESS than 1 day,
76 yrs. mos. ds.	hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Formerly a farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not Known

11- (Informant) Dores Arrington

(Address) 912 N. Bond St.

15-

Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 14-1924

17- I HEREBY CERTIFY, That I attended deceased from April 29, 1924 to May 14, 1924, that I last saw him alive on May 14, 1924, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D

5-16-, 1924 (Address) 822 N. Bond St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Asbury Cemetery	May 18, 1924
20-UNDERTAKER.	ADDRESS
Mrs R A Elliott	1735 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87068

CERTIFICATE OF DEATH.

D 87068

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 213 Chancery St., Guilford Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa C. Barry

(a) Residence No. 213 Chancery St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick T. Barry

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. 65 yrs. -- mos. -- ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, James C. Kenny

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Redmond Nolan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Miss Marie Barry
(Address) 213 Chancery St. Guilford

15- FILED MAY 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1923 to May 16 1924

that I last saw h.cr alive on May 15 1924

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Arterio Sclerosis
and Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood + Urinary findings

(Signed) Chas. N. McCleary M. D

, 19 (Address) 1415 Linden ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	5/19 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87069

CERTIFICATE OF DEATH.

D 87069

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 11 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Donaldson

(a) RESIDENCE No. Laurel Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Crandle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Cogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm Crandle

(Address) Laurel Md

15 Filed MAY 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17

I HEREBY CERTIFY, That I attended deceased from 4-21-24, 19..., to 5-18-24, 19...,

that I last saw h[illegible] alive on 5-18-24, 19...,

and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver and Gall bladder

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & lab.

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md. DATE OF BURIAL 5-19 1924

20 UNDERTAKER E & B Harlan ADDRESS 115 E Main St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37070

CERTIFICATE OF DEATH.

D 37070

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3900 Hawthorne Ave. ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charlotte Henrietta Burman

(Residence in Baltimore: No. 3900 Hawthorne Ave St.; 15 yrs., 11 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Female	W	Single

6-DATE OF BIRTH. May 27, 1908
(Month) (Day) (Year)

7-AGE. 15 yrs. 11 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER. Charles H. Burman

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Augusta S. DeHoff

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Augusta S. Burman

(Address) 3900 Hawthorne Ave

15- MAY 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 17, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1923 to May 17 1924, that I saw h.. alive on May 17 1924, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)

(Duration) about yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Walter L. Henry M. D.

May 17, 1924. (Address) 3511 Fairview Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loraine Cem. DATE OF BURIAL, 5-20, 1924

20-UNDERTAKER Thos Chas A. J. Rohde ADDRESS Lexington Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87071

CERTIFICATE OF DEATH.

6 X 184 D 87071

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary. WARD)

2-FULL NAME James Spiese

(a) RESIDENCE NO. Belcamp Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life mos. 8 ds. How long in U. S., If of foreign birth? (If non-resident give city or town and State) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown Martin

6 DATE OF BIRTH (month, day, and year) May 3/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	0	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farm Hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Phil. Fitzpatrick

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Spiese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant P. J. Martin
(Address) 125 S. 5th St. (Canton)

15 Filed MAY 18 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Terminal Broncopneumonia

(over)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into right Frontal Lobe of Brain (duration) yrs. mos. 4 ds.

(Signed) J. C. Falk, M. D.
(Coroner.)

May 18/1924 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen, Md	May 19 1924
20 UNDERTAKER	ADDRESS
Howard K Malone	Aberdeen

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

D 87072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14 001

D 87072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4539 Harford Rd ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Rea Foble

(a) RESIDENCE No. 4539 Harford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry P Foble

6 DATE OF BIRTH (month, day, and year) June 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jerome B Rea

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Susan Raleigh

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Wm Meeks

(Address) 4536 Harford

15 Filed MAY 18 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 17, 1924, that I last saw h alive on May 17, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Somers, M. D.

(Address) 4536 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	May 19 24
20 UNDERTAKER	ADDRESS
Wm J Tichner & Son	North Ave

AT E. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87073

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87073

CERTIFICATE OF DEATH.

179

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2929 N Charles St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes S. McClees

(a) Residence No. 2929 N Charles St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Dr. John S McClees

6-DATE OF BIRTH (month, day and year): Aug 10 1889

7-AGE: 34 yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Cambridge Md.

PARENTS.

10-NAME OF FATHER: Chas H. Sauerhoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Clara Hopkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

11- (Informant): Dr. John S McClees
(Address): 2929 N. Charles St

13- MAY 18 1924 HUBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 17 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 8 19 24 to May 17 19 24

that I last saw h.er alive on May 17 19 24

and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Uremia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood & urine

(Signed) Chas H. McClees, M. D

, 19 (Address) 1415 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. | DATE OF BURIAL: May 19 1924

20-UNDERTAKER: Wm J Tickner & Son | ADDRESS: Norch & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87074

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 87074

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2942 Hudson St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William D Shorr

(a) Residence No. 2942 Hudson St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Wilson

6-DATE OF BIRTH (month, day and year) Oct 24 1876

7-AGE. 47 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. George Schorr

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Yaeger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Elizabeth D Schorr

(Address) 2942 Hudson

15- Filed MAY 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16 1924

17- I HEREBY CERTIFY, That I attended deceased from May 14 1924 to May 16 1924 that I last saw him alive on May 16 1924 and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Brockunier M. D.

5-18-1924 (Address) 3037 Odonnell St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel — DATE OF BURIAL. May 19 1924

20-UNDERTAKER. John Lucas — ADDRESS 2008 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

3682 Roland Ave
Mr Marney

D87075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-0 D87075

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. Union Memorial Hospital ST., (WARD)

2-FULL NAME Earl Albert Parrish

(a) RESIDENCE No. 3924 Falls Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm E. Parrish

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Hattie L Lueck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Wm E. Parrish

(Address) 3924 Falls Road

Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Injuries received from Auto Accident

Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Fred Hemmeter M. D. (Coroner.)

May 8, 1924 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: 5/10 1924

20 UNDERTAKER: William Cook — ADDRESS: 501 E Lan

MAY—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T- 1500 Bks.

P.B.R.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87076

CERTIFICATE OF DEATH.

x65-001 D 87076

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. J. Miller Hodges

(a) RESIDENCE NO. 276 W. Washington ST., WARD Corry, Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mrs J. Miller Hodges

6 DATE OF BIRTH (month, day, and year) Oct 19. 1890

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	33	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) 055

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Owen M. Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Jenny Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Mrs J. Miller Hodges
(Address) Corry Pa

15 Filed MAY 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14 . 1924 . to May 18 . 1924.

that I last saw h[illegible] alive on May 18 . 1924,

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Myeloid Leukemia.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Corry, Penna.

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? None.

(Signed) Raymond I. Johnston, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Corry Pa.	May 18 1924

20 UNDERTAKER John A. Mitchell ADDRESS 120 N. Center St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87077

CERTIFICATE OF DEATH.

100-001

D 87077

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1821 Brunt St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Irvin Jones

(a) Residence No. 1821 Brunt St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Sept 30 1923.

7-AGE.	If LESS than 1 day,
.....yrs. 7 mos. 17 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto md
(State or Country),

PARENTS.

10-NAME OF FATHER, Lee Jones

11-BIRTHPLACE OF FATHER (city or town)..... md
(State or Country),

12-MAIDEN NAME OF MOTHER, Ida Rone

13-BIRTHPLACE OF MOTHER (city or town)..... va
(State or Country),

14- (Informant)..... Ida Jones

(Address)..... 1821 Brunt st

15- MAY 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 13, 1924 to May 17, 1924

that I last saw her alive on May 16, 1924

and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(Duration)..... yrs. ..... mos. 1 7 ds.

CONTRIBUTORY.....
(Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?..... No.....

What test confirmed diagnosis?..... none

(Signed)..... M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	May 19th, 1924
20-UNDERTAKER.	**ADDRESS**
Joseph A Frank	2319 Division st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87078

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Vincent ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Boyer

(a) RESIDENCE. No. 1635 N. Mondt ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 13, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Apartment House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Ringold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ernest Boyer

(Address) 1548 Woodyear St

MAY 1 9 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-2- 1924 to 5-16- 1924

that I last saw h[illegible] alive on 5-16- 1924

and that death occurred, on the date stated above, at 6.10 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) George C. Page M. D.

1924 (Address) 1720 N. Mondt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 20 1924
20 UNDERTAKER A. Jones	ADDRESS 111 S. Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87079

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D 87079

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 241 N. Kenwood ave St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Thomas G. Glasby

(a) Residence No. 241 N. Kenwood ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. W. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or ~~divorced~~ HUSBAND of (~~or~~) ~~WIFE of~~ Anna H. Glasby

6-DATE OF BIRTH (month, day and year) Feb. 2nd 1854

7-AGE, 70 yrs. 3 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Retired 06

(b) General nature of industry, business, or establishment in which employed (or employer) Park Guard

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Anthony Glasby

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Kath Crussey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Jas Glasby

(Address) 241 N. Kenwood ave.

15- MAY 1 9 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/5/24

17- I HEREBY CERTIFY, That I attended deceased from May 1— 1924 to May 5 1924

that I last saw ~~him~~ alive on May 3 1924

and that death occurred, on the date stated above, at. 9 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 2 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ex Cancrum

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Geo. Clinton Brooks M. D.

5/7/24 1924 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem

DATE OF BURIAL. May 9th 1924

20-UNDERTAKER. John A. Doran

ADDRESS 3000 E. Baltimore

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

Spec.—1-10-21—M&T—1500 Blks.

Mallony.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87080

CERTIFICATE OF DEATH.

100-901 D 87080

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., W ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Mallorey

(a) RESIDENCE NO. 1915 E Pratt Street ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26—1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER William Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Agnes Catherine Cleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant P. Mooney

(Address) 1915 E. Pratt St.

15 Filed MAY 1 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16th 1924

17 I HEREBY CERTIFY, That I attended deceased from March 23rd, 1924, to 5-16-, 1924, that I last saw h(im) alive on 5-16-, 1924, and that death occurred, on the date stated above, at 10 a.m. m.

The CAUSE OF DEATH* was as follows:

General paralysis.

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) R. Faulkner, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	5/19 1924
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-001

D 87081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Castle ST., 6 WARD)

2-FULL NAME Sophie K. Felder

(a) RESIDENCE NO. 217 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Felder

6 DATE OF BIRTH (month, day, and year) March 15 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	54	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Moerlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rose Feeder (Daughter)

(Address) 217 N Castle St.

15 MAY 19 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1924, to May 17, 1924.

that I last saw her alive on May 16, 1924,

and that death occurred, on the date stated above, at 1.15 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

~~contrac~~ (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) Geo McGean, M. D.

, 19 (Address) 1703 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 20 1924
20 UNDERTAKER	ADDRESS
Jos. J. Kerr	156 N. Luzerne ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 87082

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

CERTIFICATE OF DEATH.

D 87082

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Guilford ave ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Lucinda Slaughter

(Residence in Baltimore: No. 2316 Guilford ave ST.; 76 yrs., 5 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) widow

6-DATE OF BIRTH, Nov. (Month) 25th (Day), 1847. (Year)

7-AGE, 76 yrs. 5 mos. 27 ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. Arrington

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Rebecca Harris

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. E. Atkinson

(Address) 2316 Guilford ave.

15- MAY 19 1924 Filed ..... 191.. ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 17th (Day), 1924. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1924, to May 17th 1924, that I saw her alive on May 17th 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) Eugene Douglas M. D.

May 18, 1924 (Address) 820 W. North ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Co Md — DATE OF BURIAL, May 20, 1924

20-UNDERTAKER E. A. Windsor Jr. — ADDRESS 501 E 22 St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87083

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 87083

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 Penn alley ST., 4 WARD)

2-FULL NAME Charles Johnson

(a) RESIDENCE NO 640 Penn alley ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Male	Colr	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER George Johnson

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER annie Brown

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14
Informant annie Brown
(Address) 640 Penn st

Filed MAY 1 9 1924 ROBERT R. KRAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Dont Know ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Johnson, M. D.
(Coroner.)

5 18, 1924 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 19 1924
20 UNDERTAKER	ADDRESS
John H Todd	1027 Druid Hill Ave

INSTRUCTIONS FOR FILLING OUT CERTIFICATE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

87084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 ✓

D 87084

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST., 18 WARD)

2-FULL NAME Carl Brown.

(a) RESIDENCE NO. 1010 W. Franklin ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N.C

PARENTS

10 NAME OF FATHER Lott W. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C

12 MAIDEN NAME OF MOTHER Frances. Barber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C

14 Informant Lott W Brown
(Address) 423 N. Carrollton Ave.

15 MAY 19 1924 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to May 16, 1924

that I last saw him alive on May 16, 1924.

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

(duration) 2 yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Rheumatic Carditis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John M. Edmunds M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL May 19 1924

20 UNDERTAKER Harry N. Witzke ADDRESS 1534 W. Lombard

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

87085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 87085

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1007 Busch St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merle Green

(a) Residence No. 1007 Busch St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1906

7-AGE. 18 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Enamel Worker

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Pa Wyoming Co

PARENTS.

10-NAME OF FATHER Pat Green

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Sarah E Sporrer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14-INFORMANT C. Goodman

(Address) 1007 Busch

15- MAY 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 16-24

I HEREBY CERTIFY, That I attended deceased from May 11-24, 19..., to May 16-24, 19...

that I last saw him alive on May 15-24, 19...

and that death occurred, on the date stated above, at 10.45 a. m.

The CAUSE OF DEATH* was as follows:

Pul. Hemorrhage

Pul T.B.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. 4 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John G Schumacher, M. D.

, 19 (Address) 1106 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL, May 19, 24

20-UNDERTAKER. Harry D. Witzke

ADDRESS 1531 W Lombard St

WRITE PLAINLY, with unfading INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37086

CERTIFICATE OF DEATH.

REGISTERED NO. 165-001 37086

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No.) ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sabbia Falice

(a) RESIDENCE NO. 1039 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6½? mos. Extrauterine ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months 6½ Intrauterine Days If LESS than 1 day, ~~2~~ hrs ~~or 4 min~~, Extrauterine

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Frank B. Falice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sicily Italy

12 MAIDEN NAME OF MOTHER Jessie Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs Frank B. Falice

(Address) 1039 Hollins St.

15 Filed MAY 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from 3 53 a.m. May 18, 1924, to 6 45 a.m. May 18 1924.

that I last saw her alive on May 18, 1924,

and that death occurred, on the date stated above, at 6 40 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ months?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Separation of Placenta (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Pathological

(Signed) Dr. Asmptims M. D.

. 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL May 19 1924

20 UNDERTAKER John J Cavan & Son — ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87087

38 D 87087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

Registered No.....

City of BALTIMORE: (No.....St., 17 ....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Nelson Anderson

(a) Residence No. 616 Dolphin St St., ...Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Blk.	Married

5a-If married, widowed, or divorced (or) WIFE of Charles Anderson

6-DATE OF BIRTH (month, day and year) 1879

7-AGE	If LESS than 1 day.
45 yrs. mos. ds.	hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS:

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Do.

12-MAIDEN NAME OF MOTHER. Do.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Do.

14- (Informant Bay View Hospital

(Address) Baltimore, Md.

15- Filed MAY 1 9 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/13/24.

17- I HEREBY CERTIFY, That I attended deceased from June 17, 1923 to May 12, 1924 that I last saw her alive on May 12, 1924, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueteic Infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical and Serological

(Signed) H. L. Edmunds, M.D.

, 19 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	May 19, 1924.
20-UNDERTAKER.	**ADDRESS**
Mrs. Katie R. Williams	322 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87088

CERTIFICATE OF DEATH.

8 74-001

D 87088

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2245 E. Preston St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Acie D. Brocker

(Residence in Baltimore: No. 2245 E. Preston St.; yrs. life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. October 22 1862
(Month) (Day) (Year)

7-AGE. 61 yrs. 6 mns. 25 ds. If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home

9-BIRTHPLACE, (State or Country). Baltimore, Maryland

PARENTS.

10-NAME OF FATHER. Israel Leister

11-BIRTHPLACE OF FATHER, (State or Country). Carroll Co. Md.

12-MAIDEN NAME OF MOTHER. Margaret A. Armpriester

13-BIRTHPLACE OF MOTHER, (State or Country). Frederick, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Ida Leister

(Address) 2245 E. Preston St.

15- MAY 1 91924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 16th 192 4
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy-Hemorrhage

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. Collins M. D.
(Coroner.)

5-17 192 4 (Address) 506 E. North Ave.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cem	May 19 1924
20-UNDERTAKER.	ADDRESS.
Joseph B Cook	1003 N. Bond St

Spec—12-23-21—E.B.R.S.—400 Bks.

Benfer

D 87089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87089

86-001

CERTIFICATE OF DEATH.

15

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2410 Chelsea Terrace St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edwin H. Benfer .....

(a) Residence No. 2410 Chelsea Terrace St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 18, 1923

7-AGE,	If LESS than 1 day,
.....yrs. 7 mos. 28 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Rudolph H. Benfer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Pennsylvania

12-MAIDEN NAME OF MOTHER, Dorothy M. Pick

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Rudolph H. Benfer

(Address) 2410 Chelsea Terrace

15- [illegible] ROBERT R. KRAUTER, Registrar.

MAY 1 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 16, 1924,

that I last saw him alive on May 16, 1924,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Otitis Mastoid

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Syphilis

Gutis (Duration) ... yrs. ... mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Blood Wassermann Ex

(Signed) Arnold Feldstein, M. D.

5-17, 1924 (Address) Homewood Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt. Olivet Cem (Roslyn)	May 19, 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 N. Bethel St

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87090 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87090

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 E. Lexington ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Thomas

(a) RESIDENCE NO. 1110 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15-1891

7 AGE: Years 33 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: A. Sales

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Martha Thomas (Address) 1110 E. Lexington St

15 Filed MAY 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from 12/17/23, 19..., to May 17, 1924.

that I last saw her alive on May 17, 1924.

and that death occurred, on the date stated above, at 11:40 a. m.

The CAUSE OF DEATH* was as follows:

Phthisis pulmonalis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Influenza

(duration) yrs. mos. 2/ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. O. Robinson M. D.

5/19/24 (Address) 1520 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: May 20 1924

20 UNDERTAKER: Theodore White — ADDRESS: 1130 Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87091

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87091

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S Sharp ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Hurtt

(a) RESIDENCE NO. 818 S Sharp St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 12 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos. Hurt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Edna Hurt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edna Hurt

(Address) 818 S Sharp St.

15 MAY 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/15/ 1924, to 5/17/ 1924,

that I last saw her alive on 5/17/ 1924,

and that death occurred, on the date stated above, at 9.30a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cc Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas Morley M. D.

5/18/ 1924 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct.	May 19-1924
20 UNDERTAKER	ADDRESS
J. W. Thorner & Son	108 N. Monty

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87092

CERTIFICATE OF DEATH.

D 87092

4 × 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L Robinson

(a) RESIDENCE NO. Lutherville, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Robinson

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of Industry, business, or establishment in which employed (or employer) " " "

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Fiddis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant James Robinson (Address) Lutherville Md

15 MAY 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17

I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 18, 1924, that I last saw her alive on May 18, 1924, and that death occurred, on the date stated above, at 11 15 Pm.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Chronic hypertension Cardiac hypertrophy, Cerebral hemorrhage,

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Thomas Keen, M. D.

5/18 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Mt. E. Cemetery

DATE OF BURIAL May 20 24

20 UNDERTAKER John Burns Sons

ADDRESS Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 lks.

D 87093

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Wilcomeale Av ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cornish

(a) RESIDENCE. No. 509 Wilcomeale ST.; WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colloud

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE — Years: 40 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER George cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER alice Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Alice Jones 522 Wilcomeale

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MAY 19 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1924, to May 14, 1924, that I last saw h[illegible] alive on May 15, 1924, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteio Selerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R Bailey Hoag, M. D.

May 18 1924 (Address) 129 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: 5/19/24 19

20 UNDERTAKER: R L Gross — ADDRESS: 1405 McElderry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87094

58-001 D 87094

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 McTavish ST., 20 WARD)

2-FULL NAME Ora Rebecca Wheeler

(a) RESIDENCE NO. 10 McTavish ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Wheeler

6 DATE OF BIRTH (month, day, and year): 12/19/1903

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
20	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jackson Holly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Maillard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Andrew J. Holly 10 Mc. Tavish St.

15 Filed MAY 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-18- 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/10/, 1924, to 5/18/, 1924, that I last saw h[illegible] alive on 5/17/, 1924, and that death occurred, on the date stated above, at 5:45 a m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood Exam

(Signed) C. F. Jackson, M. D.

1924 (Address) 808 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: May 20 1924

20 UNDERTAKER: C. W. Dill

ADDRESS 3109 Fredk. Ave:

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87095

CERTIFICATE OF DEATH.

X 117-001 D 87095

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. 6 St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Blanche Hertel

(a) RESIDENCE NO. W Mary Lucie Southwicke Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	45	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. Hertel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary C. Ulses

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant John F. Hertel

(Address) Sutherville Md

Filed MAY 1 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1924, to 5/18, 1924, that I last saw h.. alive on 5/18, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Multiple Gastric ulcers.

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/7/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical, X-Ray, Operation

(Signed) L. M. Pelouze, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore, Cemetery	May 20 1924
20 UNDERTAKER	ADDRESS
Henry W. Miles & Son	8 & 10 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87096

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

D 87096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 824 S. East Ave, 1 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. H. Burton

(a) Residence No. 824 S. East Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward S. Burton

6-DATE OF BIRTH (month, day and year): Jan. 12, 1873

7-AGE. 51 yrs. 4 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER: Micheal Theisz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Carolina Meyers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Edward Burton

(Address) 824 S. East Ave

15- Filed MAY 19 1924, 192 ROBERT H. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from February 24 1924 to May 17 1924

that I last saw h[illegible] alive on May 16 1924

and that death occurred, on the date stated above, at 6 25 A.M.

The CAUSE OF DEATH* was as follows:

Ovarian Carcinoma

(Duration) 1 yrs. 6 mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about Nov 3/24

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Robert N. Patterson M. D

May 18 1924 (Address) 100 S Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn Cemetery	May 20, 1924
20-UNDERTAKER.	**ADDRESS**
A. Sander & Sons	1107 East St

N. B.—IN ALL PENALTY, WRITE ONLY WITH UNFADING INK—THIS IS REQUIRED BY LAW. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87097 ✓ D 87097

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2716 Fait Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Veifert

(a) Residence No. 2521 Fait Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 2, 1871

7-AGE. 53 yrs. 3 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Can Works

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS:

10-NAME OF FATHER. Julius Veifert

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Wilhelmina Housner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Mrs. Anna Korbien

(Address) 2716 Fait Ave.

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

MAY 19 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 18 ..... 1924 to May 17 19 24

that I last saw him alive on May 17th 19 24

and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Interst Furunculosis, Nephritis

(Duration) ..... yrs. 4 mos. 17 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ~~2521~~

Did an operation precede death? No Date of May 17th 24

Was there an autopsy? No

What test confirmed diagnosis? Chem + Microscop

(Signed) Geo. Hurt Dorr M. D

May 17, 1924 (Address) 40 E 20th St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lst Evangelical Cemtery	May 21 1924
20-UNDERTAKER.	**ADDRESS**
W. Vanderford Sons	1710 Fleet St

IMPORTANT. WRITE PLAINLY, USING INK. THIS IS A LEGAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87098

161-002 ✓

D 87098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Collins

(a) RESIDENCE NO. 51 Fourth Ave E. Brooklyn WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 2 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry H Collins

11 BIRTHPLACE OF FATHER (city or town) Snow Hill
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Burke

13 BIRTHPLACE OF MOTHER (city or town) Snow Hill
(State or country) Maryland.

14 Informant University Hospital
(Address) Fairfield & Greene Sts

Filed MAY 19 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1924 to May 19, 1924 that I last saw h.. alive on May 19, 1924 and that death occurred, on the date stated above, at 8-A. m.

The CAUSE OF DEATH* was as follows:

Immaturity, existed during pregnancy.

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) Ford H. Swigart M. D.

5-19-1924 (Address) Union Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	May 20 1924
20 UNDERTAKER	**ADDRESS**
H. Vander & Sons	1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87099

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 87099

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mercy Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia P. Payne

(a) RESIDENCE NO 1707 Latrobe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Virginia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Payne
(Address) 1707 Latrobe

15 Filed MAY 19 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Acc.

4 (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Forceps.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo C Bladel, M. D.
(Coroner)

May 18 1924 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 19 1924
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Eastern Ave.

INSTRUCTIONS

NAME should be entirely supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ 74 D 87100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 N Edew ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Purviance

(a) RESIDENCE NO. 426 N. Edew ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	approx 59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Purviance

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francis Wallie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs R. A. Elliott undertaker 1725 Aisquith Ave

15 MAY 9 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I attended deceased from April, 1924, to May 15 1924.

that I last saw him alive on May 14, 1924,

and that death occurred, on the date stated above, at 4 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis and nutritional insufficiency

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R Yahning, M. D.

5/19, 1924 (Address) 1429 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — DATE OF BURIAL: May 20 1924

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: 1725 Aisquith

Spec.—1-10-21—M&T—1500 Bks.

D 87101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S Marine Hospital No, — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Baltimore, Md ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. C. Daniels

(a) RESIDENCE NO. U.S. Marine Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 1 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Oiler 086

(c) Name of employer S/S Henry R. Wilson

9 BIRTHPLACE (city or town) Maine
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Self (Friend)
(Address)

15 MAY 19 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1924, to May 17, 1924,

that I last saw him alive on May 17, 1924,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Stricture of Urethra
Rupture of Urethra
Extravasation of Urine
Septicemia (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia, Acute. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 16, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Microscopical findings of Urine

(Signed) H. C. Daniels M. D.

(Address) U.S. Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portland Maine — DATE OF BURIAL 5/19 1924

20 UNDERTAKER Sol Linson & Bro — ADDRESS E Belt 627

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87102

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 W. Lanvale ST., 16 WARD)

2-FULL NAME Matilda Ann Mitchell

(a) RESIDENCE NO. 1415 W. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of George Thomas Mitchell

6 DATE OF BIRTH (month, day, and year) Sept 14-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....—

(c) Name of employer —

9 BIRTHPLACE (city or town) Prince George Co, (State or country) Md

PARENTS

10 NAME OF FATHER ? Crook.

11 BIRTHPLACE OF FATHER (city or town) Prince George Co, (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Matilda Droge

13 BIRTHPLACE OF MOTHER (city or town) Prince George Co, (State or country) Md.

14 Informant Mrs F. D. Murray.
(Address) 1415 W. Lanvale St

15 Filed MAY 19 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1922, to May 17-, 1924,
that I last saw her alive on May 15-, 1924,
and that death occurred, on the date stated above, at 5.55 8 m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & Fehling's Test.

(Signed) Chester Riland, M. D.

5-17. 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	5/20/24
20 UNDERTAKER	ADDRESS
Geo. A. Tuley	Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 87103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-0020 87103

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 421 N. Durham St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Butler

(a) Residence No. 1421 N. Durham St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Butler

6-DATE OF BIRTH (month, day and year) not Known

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Alfred Jenkins

11-BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant) Alfred Jenkins

(Address) 421 N. Durham

15- MAY 19 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-18-24

17- I HEREBY CERTIFY, That I attended deceased from March 10, 1924, to May 18, 1924,

that I last saw h. alive on May 1, 1924

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Clay Burns, M. D.

May 19, 1924 (Address) 1421 N. 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, May 21, 1924

20-UNDERTAKER, Edward Bryan ADDRESS 631 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87104

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 525 Bloom ST., 14 WARD)

2-FULL NAME Myrtle Catherine Conway

(a) RESIDENCE NO. 525 Bloom ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Conway

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Eloise Wood

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant John Conway
(Address) 525 Bloom St

15 Robert P. Harrison, Registrar

Y 1 91924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1924, to May 18, 1924, that I last saw her alive on May 17, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

Probably 2 or 3 (duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage 1 hr. (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Dr William Frey, M. D.

5/18, 1924 (Address) 927 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lion Cemetery	May 20 1924
20 UNDERTAKER Jesse Ridden.	ADDRESS 436 Bradd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87105

100-001

D 87105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 29 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Harry White

(a) Residence No. 1626 Light Street St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Alex White

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), West Virginia

12-MAIDEN NAME OF MOTHER, Lucy White

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), West Virginia

14- (Informant) Mr. White Brother

(Address) 1626 Light St.

15- MAY 19 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/19/24

17- I HEREBY CERTIFY, That I attended deceased from March 26 1924 to May 19 1924

that I last saw him alive on May 19 1924

and that death occurred, on the date stated above, at 1-15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Varicose Ulcer - Rt. Leg

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) M. J. Gallen M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cedar Hill Cem DATE OF BURIAL. 5/21 19 24

20-UNDERTAKER, J. Frew McCurdy ADDRESS 130 E. Fort

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ... instructions on back of certificates. See

Cor.—1-12-23—M&T—100 Bks.

D 87106

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 D 87106

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 E. Pratt ST. 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hohl. (Schweitzer)

(a) RESIDENCE NO. 830 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Not Dead

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) — 087
(c) Name of employer

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant.....
(Address) UNIVERSITY OF MARYLAND.

15 MAY 9 1924 Robert P. Garrison
Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) Inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(Duration) yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos 1 ds.

(Signed) Geo E Blades, M. D.
(Coroner.)
5/9/24 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87107

CERTIFICATE OF DEATH.

D 87107

68

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Jail ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest Vaughn

(a) RESIDENCE NO Not Known, ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Not Known

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) jail
(c) Name of employer —

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant .....
(Address) .....

15
Filed ..... 192 .....
Registrar

MAY 19 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(duration) Hrs ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Bayless, M. D.

5/19/24 192 (Address) 173 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

MAY 19 1924

Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87108

CERTIFICATE OF DEATH.

161-00 D 87108

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Wheeler Ave ST., 20 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jenkins Jr

(a) RESIDENCE NO. 7 N Wheeler Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 18-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James Jenkins

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Rose Sinnott

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14
Informant .....
(Address) .....

MAY 19 1924 Robert F. Barrick, ... 19
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17
I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to May 18, 1924, that I last saw him alive on May 18-24, 19....., and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

Prematurity 5 mos Utero
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward Cohen, M. D.

, 19 (Address) 2105 N Gallo Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: MAY 19 1924

20 UNDERTAKER: Commissioner Health — ADDRESS

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.—WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87109

161-00D 87109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 N. Mount. ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wright

(a) RESIDENCE NO. 1425 N. Mount. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. 36 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ddd

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) 1423 N. Mount St.
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Roland Wright

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Whelon

13 BIRTHPLACE OF MOTHER (city or town) Washington
(State or country) D.C.

14 Informant Louise Wright
(Address) 1423 N. Mount St. Baltimore, Md.

MAY 19 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-18, 1924, to 5-18, 1924,

that I last saw him alive on 5-18, 1924.

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Susanne R Parsons, M. D.

5-18, 1924 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: MAY 19 1924

20 UNDERTAKER: Commissioner Health.

ADDRESS .....

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Vaeth)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87110

CERTIFICATE OF DEATH.

161-00

D 87110

1-PLACE OF DEATH Church Home & Inf. 8

CITY OF BALTIMORE: No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Zeuch

(a) RESIDENCE NO. 1506 Register St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Wh.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 5/16/24.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edgar F Zeuch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary K Mathes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mother
(Address) .....

MAY 1 1924 Robert F. Harrison
..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/16, 1924, to 5/16, 1924.

that I last saw h alive on 5/16, 1924.

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) [redacted]

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Copeland Pantleton M.D.

, 19 (Address) Church Home Inf Dp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Rohrer. State Board

DATE OF BURIAL 19 1924

20 UNDERTAKER .....

ADDRESS .....

Burial Permit Clerk

PER. REG. E. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

D 87111

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-002 ✓ D 87111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. T. Brown

(a) RESIDENCE NO. 1626 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cooper.
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chesterfield, Va.

PARENTS

10 NAME OF FATHER Benj. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Octavia Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant G. H. Brown
(Address) 918 N. Freeman St.

15 Filed MAY 19 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

May 18, 1924 (Address) 200 Fawn

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 20 1924
20 UNDERTAKER	ADDRESS
A. J. Marshall	2534 Pulaski

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87112

D 87112

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Cread ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry O. Butner

(a) RESIDENCE NO. 112 Cread ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary Butner

6 DATE OF BIRTH (month, day, and year) Aug. 18. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	67	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paymaster of Pa. R.R

(b) General nature of industry, business, or establishment in which employed (or employer) 673

(c) Name of employer Penna R R

9 BIRTHPLACE (city or town) (State or country) Mt Washington Md

PARENTS

10 NAME OF FATHER Michael Butner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kellar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Butner

(Address) 112 Cread ave

15 Filed MAY 19 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1923, to May 17, 1924,

that I last saw him alive on May 17, 1924,

and that death occurred, on the date stated above, at 5. a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's - Arteio Sclerosis

Mitral Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) C. H. Beeten, M. D.

5.18. 1924 (Address) Mt Washington Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 21 1924
20 UNDERTAKER	ADDRESS
A S Mankell	3539 Fal Road

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87113

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Saint Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Curtis

(a) RESIDENCE NO. 1729 Wilkins Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank C. Curtis

6 DATE OF BIRTH (month, day, and year) Apr. 19, 1893

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert T. Harris

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Mary Gittings

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Frank C. Curtis
(Address) 1729 Wilkens Ave.

15 Filed MAY 19 1924 Robert P. Harrison, Registrar

Burial Permit clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to May 19, 1924;

that I last saw her alive on May 19, 1924;

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Acute Sanguinous Appendicitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Jaundice Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? Yes Date of May 8-24

Was there an autopsy? No.

What test confirmed diagnosis? Op. & Clinical

(Signed) James H. Wilkerson, M. D.

5-19-24 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 22 1924
20 UNDERTAKER	ADDRESS
Geo. L. Cook	1003 W. Baltimore St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 19 1924

Spec.—1-10-21—M&T—1500 Bks.

D 87114

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87114

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 Leadenhall ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie ~~A.~~ Smith

(a) RESIDENCE NO. 843 Leadenhall ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. ~ mos. ✓ ds. How long in U. S., if of foreign birth? ~ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Smith

6 DATE OF BIRTH (month, day, and year) Nov. 6. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER George Daughtrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Frederick Smith (Address) 843 Leadenhall St.

15 Robert P. Harrison, Registrar

MAY 19 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1924, to May 17th, 1924, that I last saw her alive on May 17th, 1924, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis & Mitral Regurgitation

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) August Horn, M. D.

, 19 (Address) 40 E 26th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltocity — DATE OF BURIAL 5/20 1924

20 UNDERTAKER Margaret C. Flynn — ADDRESS 422 Light St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87115

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D 87115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 E. 31 St. ST., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Augustus James

(a) RESIDENCE NO 318 E. 31 St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora James

6 DATE OF BIRTH (month, day, and year) Apr 25-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	0	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer 63
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) Rochester
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Richard F. James

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Maria Russel

13 BIRTHPLACE OF MOTHER (city or town) Rochester
(State or country) N. Y.

14 Informant Mrs Cora James
(Address) 318 E. 31st St.

15 Filed MAY 19 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Scott Morrison M. D.
(Coroner.)

May 19, 1924 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. Olivet Cem	May 21 1924
20 UNDERTAKER Wm. J. Sickmen & Sons	ADDRESS N. Pa

MAY 19 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statemen
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87116

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 E. Fort ave. St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Bittner

(a) Residence No. 1126 E. Fort Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Claudia Bittner.

6-DATE OF BIRTH (month, day and year) July 29, 1845

7-AGE. 78 yrs. 9 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer O&O

(b) General nature of industry, business, or establishment in which employed (or employer). Retired

(c) Name of employer. Standard Oil Co

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Richard Bittner.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Anna Bittner. (Address) 1126 E Fort ave

15- Filed ....., 192.... Robert F. Carrison, Registrar.

Wm. Pratt Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 17th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 13 1924 to May 17 1924

that I last saw him alive on May 16 1924

and that death occurred, on the date stated above, at 4.50a m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstetial Nephritis

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Thos. F. Stevens M. D.

5/18, 1924 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 20, 1924
20-UNDERTAKER,	ADDRESS
Margaret Dr. Flynn	1422 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 87117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87117

CERTIFICATE OF DEATH.

94-od

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1213 Hull St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ann Moss Nixon

(a) Residence No. 1213 Hull St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single. Married. Widowed. Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 14 1897

7-AGE. 27 yrs. 4 mos. 4 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, George H. Nixon

11-BIRTHPLACE OF FATHER (city or town). (State or Country), England

12-MAIDEN NAME OF MOTHER, Harriett Cooper

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), England

14- (Informant) Mrs. Nixon (mother)

(Address) 1213 Hull St.

MAY 20 1924

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 18th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 6th, 1924, to May 18th, 1924, that I last saw h.. alive on May 17th, 1924, and that death occurred, on the date stated above, at 5.30 AM

The CAUSE OF DEATH* was as follows:

Convulsions (Epileptic).

Exhaustion & inanition from frequent & severe attacks during the past 2 weeks - Infrequent attacks from early childhood (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of?

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jennie R. Burns, M. D

May 19. 1924 (Address) 1223 S. Charles St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn Cemetery	5/20, 1924
20-UNDERTAKER.	**ADDRESS**
I. Few McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS ESSENTIAL. EVERY ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87118

CERTIFICATE OF DEATH.

384 87118

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Bayview Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cardoza

(a) Residence No. 818 George St St., ... Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, (Married) Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Cardoza

6-DATE OF BIRTH (month, day and year) 1870

7-AGE 54 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) ? 040

(c) Name of employer ?

9-BIRTHPLACE (city or town) (State or Country), ~~Louisiana~~ Cal.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Bay View Hospital

(Address) .....

Filed MAY 20 1924 192

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-17-24

17- I HEREBY CERTIFY, That I attended deceased from 7/29, 19 20 to 5/17, 1924 that I last saw h. alive on 5/17, 1924 and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of insane)

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Luetic infection

(Duration) ? yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Serological

(Signed) N. Grechowski M. D.

5/19/ 1924 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 5-21, 1924
Mt Auburn	
20-UNDERTAKER, Daniel Easton	ADDRESS 516 Pa ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

B 87119

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-091

B 87119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 W. West St. ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James T. Berger. (C)

(a) RESIDENCE NO 503 W. West St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 4 ds. How long in U. S., If of foreign birth? --- yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 14, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	---	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Russell Berger. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah Smith. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Sarah Berger. (C) mother.
(Address) 503 W. West St.

MAY 20 1924

ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia.

Oedema of the Lungs.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

May 13, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. — DATE OF BURIAL 5-20 1924

20 UNDERTAKER David Easton — ADDRESS 716 Pa ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87120

CERTIFICATE OF DEATH.

38 D 87120

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bayview hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Bantam

(a) Residence No. Bayview Hospital St., Ward Insane Department
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Bantam

6-DATE OF BIRTH (month, day and year)

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? Odd

(c) Name of employer ?

9-BIRTHPLACE (city or town) (State or Country),

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Mrs. Bantam

(Address) 1741 Presbt. St.

15- Filed MAY 2 0 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/16/24

17- I HEREBY CERTIFY, That I attended deceased from 7/22, 19 22 to 5/16, 19 24, that I last saw h. alive on 5/16, 19 24, and that death occurred, on the date stated above, at 10:45 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis.

(Signed) A. Goldsmith M. D.

, 19 (Address) Bayview Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Arbutus Cemetery — DATE OF BURIAL, May 20 1924

20-UNDERTAKER, Edward Bazon — ADDRESS 1631 Orleans St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87121

CERTIFICATE OF DEATH.

5/ D 87121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Frey

(a) RESIDENCE No. 420 Luzon St. ST., WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westmoreland Co Va

PARENTS

10 NAME OF FATHER: Marcellus Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Lucy Ann Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Marcellus Frey

(Address) Va

15 MAY 20 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/24

17 I HEREBY CERTIFY, That I attended deceased from March 23 1924 to May 18 1924.

that I last saw h er alive on May 18 1924.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Inflamatory Rheumatism

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Marcellus E. Frey M. D.

, 19 (Address) 1745 N Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: May 20 1924

20 UNDERTAKER: Samuel Wamsley ADDRESS 178 N Bridge

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87122

CERTIFICATE OF DEATH.

+90 D 87122

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 824 W. Saratoga St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Thomas

(a) Residence No. 824 W. Saratoga St., Ward Kent Co. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Two mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced. (Write the word.): married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: not known

6-DATE OF BIRTH (month, day and year): August—1896

7-AGE: 27 yrs. 8 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: none

9-BIRTHPLACE (city or town) (State or Country): Sandy Bottom Kent Co. Md.

PARENTS.

10-NAME OF FATHER: Frank Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country): not known Virginia

12-MAIDEN NAME OF MOTHER: Rosa Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Sandy Bottom Kent Co. Md

14-

(Informant): Mrs Mary Neil

(Address): 824 W. Saratoga St

15-

Filed MAY 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 24, 1924 to May 18, 1924

that I last saw him alive on May 18, 1924

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart

(Duration) Two yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral thrombosis

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death? Chester, Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John E. Hamper, M. D.

, 19 (Address) 1405 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Colchester Md	5-20, 19 24
20-UNDERTAKER,	ADDRESS
Daniel Easton	916 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkw.

D 87123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87123

CERTIFICATE OF DEATH.

114

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N. Parish St., 19 WARD)

2-FULL NAME Moses Henson

(a) RESIDENCE NO. 515 N. Parish St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	10	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER John Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy Tilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robt. Henson
(Address) 515 Penna. Ave.

15 MAY 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 5 yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

(Address) 200 Redwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Gon. Cem. DATE OF BURIAL May 20th 1924

20 UNDERTAKER C. Jones ADDRESS 111 S. Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87124

CERTIFICATE OF DEATH.

D 87124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 15 WARD)

REGISTERED NO. 15 192

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Robey

(a) RESIDENCE No. 2118 Ridgewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Robey

6 DATE OF BIRTH (month, day, and year) Dec. 10 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) United Railways
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER George Walker Robey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C.

12 MAIDEN NAME OF MOTHER Sarah Mabbden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Annie E. Robey
(Address) 2118 Ridgewood Ave

15 Filed MAY 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gunshot wound.
Homicide

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 1 ds.

(Signed) Geo Clinton Stadler, M. D.
(Coroner)
(Address) 143 Holliday

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 21 1924
20 UNDERTAKER Josiah Syfer	ADDRESS 1600 W. North Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 87125

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 185

CITY OF BALTIMORE. (No.) ST., (WARD) (If occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Clark

(a) RESIDENCE No. 250 W. Fairmount ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 7 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Thos. Clark

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Primrose

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edith Clark
(Address) 2572 Pennsylvania ave

15 [illegible]

MAY 20 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1924

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell down

(duration) yrs. mos. ds.

(Signed) Thos. B. Thornton, M. D.
(Coroner.)

May 19 1924 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 20 1924
20 UNDERTAKER	ADDRESS
Josiah Ryfer	1600 N. Pont. ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 87126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 S. Linwood Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Michael

(a) RESIDENCE NO. 1104 S. Linwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 - 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) 1104 S. Linwood Ave
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Michael

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Brussans Poland

12 MAIDEN NAME OF MOTHER Eva Petro

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant John Michael
(Address) 1104 S. Linwood ave

15 Filed MAY 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1924

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to May 17, 1924, that I last saw him alive on May 17 - 1924, and that death occurred, on the date stated above, at 11:05 P. m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Improper Feeding

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J. Davidow, M. D.

, 19 (Address) 303 E. O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	May 20 1924
20 UNDERTAKER	ADDRESS
Stephen C. Tallbrooks	W. Lemmon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Struck

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87127

CERTIFICATE OF DEATH.

100-001

D 87127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., No. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Struck, Jr.

(a) RESIDENCE NO. 0 Donnell & 22d St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., If of foreign birth? 25 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Struck

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	38		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 045

(b) General nature of industry, business, or establishment in which employed (or employer) Produce Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Struck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant [illegible] Broad.
(Address)

15 Filed MAY 20 1924 19.... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/24

17 I HEREBY CERTIFY, That I attended deceased from 5/12/24 19.... to 5/18/24 19....

that I last saw h[illegible] alive on 5/18/24 and that death occurred, on the date stated above, at 9.05-a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

[illegible] an operation precede death? No Date of

[illegible]s there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Mean[illegible] and Nature of Injury, and (2) whether Accidental, Suicidal, or Hom[illegible]. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Stanton Cem	5/21 1924
20 UNDERTAKER	ADDRESS
Stephen F. Falbourker	22 St James Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

D 87128

CERTIFICATE OF DEATH.

D 87128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S. Washington ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roman M. Nadolny

(a) RESIDENCE NO. 614 S. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 18-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Stephan Nadolny,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, MD.

12 MAIDEN NAME OF MOTHER Antonina Wiatrowski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Antonina Nadolny, (Mother)

(Address) Chase, Balto., Co. MD.

15 MAY 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to May 19, 1924.

that I last saw him alive on May 19th, 1924.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Tracheitis (Acute)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pemphigus (acute)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Chase Balto Co. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ST. STANISLAUS CEMETERY	May 20. 1924.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 87129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N Spring ST., 5 WARD)

2-FULL NAME Jessie Brown

(a) RESIDENCE NO. 14 N Spring ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rachael Brown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Apprx 42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte N C.

PARENTS

10 NAME OF FATHER Prince Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C.

12 MAIDEN NAME OF MOTHER Emma Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C.

14 Informant Rachael Brown wife

(Address) 14 N Spring St

15 F... MAY 2 0 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1924, to May 18, 1924,

that I last saw him alive on May 16, 1924,

and that death occurred, on the date stated above, at 4 45 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

unknown

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. T. Young, M. D.

1924 (Address) Hebrew Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry Cem	5/20 1924
20 UNDERTAKER	ADDRESS
Jas. M. Simmons	30 E. Read St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 87130 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87130

CERTIFICATE OF DEATH.

5 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 1020 E. Baltimore St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Blumenthal

(a) Residence No 1020 E. Balto Street St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Blumenthal

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 40 yrs. — mos. — ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) General Indse

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Henry Blumenthal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Leno —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14-

(Informant) Jack Lewis

(Address) 1439 E. Balto St

15-

Filed MAY 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5/20/24

17- I HEREBY CERTIFY, That I attended deceased from May 19 19 24 to May 20 19 24

that I last saw h[illegible] alive on 5/20 19

and that death occurred, on the date stated above, at 4-40 p. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Arteriosclerosis

Chronic Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Nicholas Taylor M. D.

5/20, 19 24 (Address) 124 South Exeter St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Washington Blvd DATE OF BURIAL. 5/20, 19 24

20-UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87131

CERTIFICATE OF DEATH.

5 21 D 87131

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105. Low st. St., 5 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna LaDeca

(a) Residence No. 1105. Low St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. 2 ds. How long in U. S., if of foreign birth? 2 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3/19-1924

7-AGE 2 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Vincenzo La Deca

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Maria Colaiami

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Vincenzo La Deca

(Address) 1105 Low St

15- MAY 20 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/19/24

17- I HEREBY CERTIFY, That I attended deceased from May 19 1924 to May 20 1924 that I last saw b. alive on May 19 1924 and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Enteritis of Baby

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Andy L. Lucchesi M. D.

May 20 1924 (Address) 1038 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents Cem — DATE OF BURIAL. 5/20/24

20-UNDERTAKER. George J Ruth — ADDRESS. 1735 Harford Ave

Had Enteritis about 1 week, from May 2-9—

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87132

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87132

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital 162

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Swope

(a) RESIDENCE NO. Washington & Allegheny Ave ST., ... WARD ..... Towson Md.

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 5/7 hrs. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md. Maryland

PARENTS

10 NAME OF FATHER Harry F. Swope Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Theodora H. Atterbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co. Maryland

14 Informant Harry F. Swope Jr.
(Address) Towson Md.

15 MAY 21 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from 3:20 a.m. May 19, 1924, to 12:25 P.m. May 19, 1924.

that I last saw him alive on May 19, 1924

and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Weight 4 lbs 6½ oz.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes. Partial. Brain examined.

What test confirmed diagnosis? Clinical.

(Signed) Otto A. [illegible] M. D.

, 19 (Address) 1 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 20 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Lombard St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87133 — 74-001 — D 87133

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Warner ST., 21 WARD)

2-FULL NAME Amanda Jenkins

(a) RESIDENCE NO. 718 Warner St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem'l

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Jenkins

6 DATE OF BIRTH (month, day, and year): Oct 10 1871

7 AGE — Years: 53 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Edward Jenkins
(Address) 718 Warner St.

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MAY 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 19 24

17 I HEREBY CERTIFY, That I attended deceased from May 15, 19 24, to May 17, 19 24, that I last saw him alive on May 17, 19 24 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) ..... yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia - Arteriosclerosis (duration) ..... yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Bernard L. Sneed, M. D.

19, 19 24 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem'y — DATE OF BURIAL: May 21 1924

20 UNDERTAKER: Mrs P. C. Elliott — ADDRESS: 1125 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87134

CERTIFICATE OF DEATH.

105 87134

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 312 So. Fulton St. (Ward) 19

2-FULL NAME John Benner

(a) RESIDENCE NO 312 So. Fulton Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Benner

6 DATE OF BIRTH (month, day, and year) May 28 / 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John A. Benner (Address) 312 So. Fulton ave

15 Filed ..... 192 MAY 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Old age & Heart Failure

(duration) ... mos. ds.

(Signed) Dr. S. B. Horton, M. D.

May 19th, 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL May. 20 1924

UNDERTAKER Geo. L. Schwab ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 87135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87135

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 541 N. West ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Johnson

(a) RESIDENCE. No. 541 N. West ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Churchill Ballard

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Edna Johnson

(Address) 111 Russell St

15 Filed MAY 20 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1924

17

I HEREBY CERTIFY, That I attended deceased from April 13th, 1924, to May 17th, 1924, that I last saw h[illegible] alive on May 17th, 1924 and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Abcess of Foot

Cancer yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. L. Shelton, M. D.

5/17 1924 (Address) 1320 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	21 May 1924
20 UNDERTAKER	ADDRESS
I L Brown & Son	108 W Monto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87136

CERTIFICATE OF DEATH.

90 D 87136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4740 Park Heights ave. ST. 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Ellen Horn

(a) RESIDENCE. No. 4740 Park Heights ave. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James John W. Horn

6 DATE OF BIRTH (month, day, and year) Sept 6. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. Emmart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane F. Armfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura V. Emmart (Address) Hungerford Md.

15 Filed MAY 20 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17

I HEREBY CERTIFY, That I attended deceased from May 11 1924 to May 19 1924 that I last saw her alive on May 19 1924 and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? \

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Gibert M. D.

19 (Address) 4854 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Loudon Park Cemetery May 22 1924

20 UNDERTAKER, ADDRESS

Chas C. Mitchell 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87137

CERTIFICATE OF DEATH.

60-001 D 87137

1-PLACE OF DEATH Univ. Hospital. REGISTERED NO.....

CITY OF BALTIMORE. (No. Horace ST., 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME [redacted] P. D. Jarrett (Garrett)

(a) RESIDENCE No. 1403 Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Garrett

6 DATE OF BIRTH (month, day, and year) May 1 1879.

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Business College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md

PARENTS

10 NAME OF FATHER Ephriam N. Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cornelia L Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Gertrude Garrett (Address) 1403 Longwood St

15 Filed MAY 2 0 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/15/24, 19..., to 5/19/24, 19...,

that I last saw him alive on 5/19/24, 19...,

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre.

(duration) 2 yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Above + Clinical findings

(Signed) [redacted] M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Lutheran Cem Manchester Carroll Co Md	May 21 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

D 87138

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D 87138

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 98 Forest Ave

CITY OF BALTIMORE: (No. Hillsdale ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mahlon Robert ~~Doctor~~ Scherer Jr.

(a) RESIDENCE NO. Hillsdale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 19 1924

7 AGE	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1 Day.			

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hillsdale
(State or country) Baltimore - Amer

PARENTS

10 NAME OF FATHER Mahlon R Scherer Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore City.

12 MAIDEN NAME OF MOTHER Carie E. Bell

13 BIRTHPLACE OF MOTHER (city or town) Frankleytown
(State or country) Md

14 Informant Mrs M. R. Scherer
(Address) Hillsdale

15 Filed MAY 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19 24, 19 . to May 20 . 1924.

that I last saw h in alive on May 19 about 1 P m.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Premature birth (about 6 Mo)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature birth (about 6 Mo) about 18 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical.

(Signed) W S Nisbet, M. D.

May 20. 1924 (Address) 2220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL 5-20 1924

20 UNDERTAKER J. Fraley's Sons — ADDRESS 1315 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D 87139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 ✓ D 87139

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Division ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Borze

(Residence in Baltimore: No. 1209 Division St.)

40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-~~SINGLE~~, MARRIED, WIDOWED, ~~OR DIVORCED~~, (~~Write the word.~~) Widower

6-DATE OF BIRTH, ..., 1857
(Month) (Day) (Year)

7-AGE, 67 yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): Dealer Oys

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William Borze

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Nancy Boom

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Smith

(Address) 1209 Division St

15- [illegible]

Filed MAY 20 1924, 191.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May — 19 —, 1924
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Apr 16 1924 to May 19 1924, that I saw him alive on May 18 1924, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Senility
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastritis
(Duration) yrs. 2 mos. ds.

(Signed) J B Hughes M.D.

May 19, 1924 (Address) 1413 S. Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mont Auburn — DATE OF BURIAL, May 21, 1924

20-UNDERTAKER John A Owens — ADDRESS 53 S Exeter

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87140

CERTIFICATE OF DEATH.

14-60 D 87140

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 928 S. First ST., No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Berl

(a) RESIDENCE NO. 928 S. First ST., ... WARD .....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roseanna Berl

6 DATE OF BIRTH (month, day, and year) March 21-1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer National Casket Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Berl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Deems

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elmer Berl

(Address) 1200 S. Linwood ave

15 Filed ..... 19 .....

Robert F. Carrison

Registrar

Burial Permit Clerk.

MAY 20 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to May 19, 1924.

that I last saw ~~him~~ alive on May 19, 1924.

and that death occurred, on the date stated above, at 3 20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tilton M. D.

5/19, 1924 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	May 22 1924
20 UNDERTAKER Pirkler & Pirkler	ADDRESS 1739 Eager

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87141

CERTIFICATE OF DEATH.

100 D 87141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 Thames ST., W WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Zamiauskí

(a) RESIDENCE No. 1618 Thames ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant ..... (Address) .....

15 Filed MAY 20 1924 Robert F. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. X ds.

(Signed) Geo. C. Blades, M. D.
(Coroner)

5/19/24 192 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL MAY 20 1924

20 UNDERTAKER Baltimore Health, ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87142

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier 5 - Patt St. St., 4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Brown

(a) RESIDENCE NO Wm Brown ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	—		—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

187

9 BIRTHPLACE (city or town) —
(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country) —

14
Informant .....
(Address) .....

15 Filed ..... 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to hes death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning
Acc.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. C. Blade, M. D.
(Coroner)

5/19/24, 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	MAY 20 1924 192
20 UNDERTAKER Commissioner Health,	ADDRESS

For Wm. S. WOODALL

Robert F. Harrison,
Burial Permit Clerk

W 2 01924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87143

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3354 Chestnut Ave 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester A Jardine

(a) Residence No. 3354 Chestnut Ave Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6-DATE OF BIRTH (month, day and year): June 3 1888

7-AGE: 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Paver

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF Archibald Jardine

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Lydia A Peddicord

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-

(Informant): Archibald Jardine

(Address): 3354 Chestnut Ave

15-

Filed: [illegible] Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 19 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to May 19, 1924, that I last saw h.. alive on May 19, 1924, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Gastric Haemanaghr

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chron Gastritis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Appendicitis

(Signed) [illegible], M. D.

5-[illegible], 19 24 (Address) 2700 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL, May 22, 1924

20-UNDERTAKER: CHENOWETH & SON,

ADDRESS 2617 CHESTNUT AVE

Burial Permit Clerk

IMPORTANT. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important. AGE should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Williams

(a) RESIDENCE NO. 1401 Myrtle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Black	Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of John Williams

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —"—

(c) Name of employer —"—

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Cornelious Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Esther Valley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 MAY 20 1924 Robert P. Harrison, . 19 Registrar

R. H. P. Pratt clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1924, to May 19, 1924.

that I last saw her alive on May 19, 1924.

and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth, Va.

DATE OF BURIAL May 20 19 24

20 UNDERTAKER Jno. M. Shivers

ADDRESS 1307 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87145

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hosp. ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas D. Clarken

(a) RESIDENCE NO. 1422 W 36th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Clarken

6 DATE OF BIRTH (month, day, and year) Dec. 16-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Poole, Eng. & M. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Clarken

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irelgnd

12 MAIDEN NAME OF MOTHER Ann Dowling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Irelandt

14 Informant Geo. F. Clarken

(Address) 132 Du Pont St. Edmonston

15 Filed MAY 20 1924 Robert E. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1924, to May 19, 1924, that I last saw him alive on May 18, 1924; and that death occurred, on the date stated above, at 5-10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach

Metastases (duration) yrs. mos. ds. Bilat. ing. hernia Varicose Vein Leg

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B Lybeck, M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 21 1924

20 UNDERTAKER Horace A. Bruce — ADDRESS 1631 Fallsd.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87146

109-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 714 S. Pat St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary A. Gootz

(a) Residence No. 714 S. Pat St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 8-1923

7-AGE. ....yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... City

(State or Country).....

PARENTS.

10-NAME OF FATHER, Caspar Gootz

11-BIRTHPLACE OF FATHER (city or town)..... City

(State or Country).....

12-MAIDEN NAME OF MOTHER, Marie Trautfelter

13-BIRTHPLACE OF MOTHER (city or town)..... City

(State or Country).....

14- (Informant) Marie Gootz

(Address) 714 S. Pat St.

19 20 1924

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/19/24

17- I HEREBY CERTIFY, That I attended deceased from 15 May, 1924, to 19 May, 1924, that I last saw her alive on 19 May, 1924, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Abscess, Retropharyngeal

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 18 May 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Gilbert W. Rosenthal, M. D.

19 May, 1924 (Address) 2426 Eutaw Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. H. of R. Redemptorist

DATE OF BURIAL. 5/21/24, 19....

20-UNDERTAKER. L. C. Moran

ADDRESS 2 Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87147

CERTIFICATE OF DEATH.

65-09

1-PLACE OF DEATH

City of BALTIMORE: (No. 1615 E. 33rd St., 9 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia A. O'Connor

(a) Residence No. 1615 E. 33rd St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of John E. Connor

6-DATE OF BIRTH (month, day and year) Jan 22 1865

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Michael Simmons

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Hayes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Vincent O'Connor

(Address) 1615 E. 33rd St.

15- Filed May 20 1924 Robert P. Harrison, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 18-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922, to May 18th, 1924, that I last saw h. alive on May 18th, 1924, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Duration 2 yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Glenn, M. D.

May 14, 1924 (Address) 1502 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, 5/21, 1924

20-UNDERTAKER, J. A. Moran ADDRESS 300 E. Baltimore St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 20 1924

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87148

CERTIFICATE OF DEATH.

100 D 87148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 345 W. Preston ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Leroy Forrest

(Residence in Baltimore: No. 345 W Preston St.; ..... yrs., 2 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, March 18, 1922 (Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Marshall

11-BIRTHPLACE OF FATHER (State or Country), Md Forest

12-MAIDEN NAME OF MOTHER, Frances Williams

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances Forest

(Address) 345 W Preston St

15-

Filed ....., 191.. Robert F. Morrison, Registrar.

MAY 20 1924 Muriel Perrit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19th, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 12- 1924, to May 19- 1924, that I saw h[illegible] alive on May 18- 1924, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Mal nutrition

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Chas. J. Keller M. D.

May 20, 1924 (Address) 222 Monument E.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Cem. DATE OF BURIAL, May 20, 1924

20-UNDERTAKER Samuel Hawley ADDRESS 1711 Bd Balto

3—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 87149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87149

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Walker

(a) Residence No. 1732 Division Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colred

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874

7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia.

PARENTS.

10-NAME OF FATHER, Andrew Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Westmoreland Co. Virginia

12-MAIDEN NAME OF MOTHER, Ann Hungerford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Westmoreland Co. Virginia

14- (Informant) Fannie Marshall

(Address) 1732 Division St

15- Filed MAY 2 1924 Robert P. Barnes, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/18/24.

17- I HEREBY CERTIFY, That I attended deceased from February 14, 1924 to May 18, 1924

that I last saw her alive on May 18, 1924

and that death occurred, on the date stated above, at 1-00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

General Metastasis and

Cachexia

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. P. Sutton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL, May 24 1924

20-UNDERTAKER Smith & Wemsley ADDRESS N. Eutaw St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Gwatkney)

D 87150

HEALTH DEPARTMENT—CITY OF BALTIMORE

87150

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 418 Mosher ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Gwathney

(a) RESIDENCE NO. 418 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William J. Gwathney

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years 47; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

070

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Thomas Fatney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Jemima Richie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: W. J. Gwathney

(Address): 418 Mosher St

15 MAY 20 1924

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14— 1923 to May— 18 1924

that I last saw h[illegible] alive on May 18 1924

and that death occurred, on the date stated above, at 5:40 P.M.

THE CAUSE OF DEATH* was as follows: Pulmonary Emphysema

(duration) yrs. 4 mos 18 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? 4 months 14 weeks

Did an operation precede death? Date of

Was there an autopsy? Saturday 17 of Spotone

What diagnosis was confirmed by autopsy? Chronic Mod. T. B.

(Signed) W. J. Coleman M. D.

(Address) 2039 McCulloh

May 20 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: May 21 1924

20 UNDERTAKER: Samuel H. Hawley

ADDRESS: 1 Bridge

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87151

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 W. Lanvale St. 17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Greensboro N. Co.

2-FULL NAME Daisy Louise Height

(a) RESIDENCE. No. 632 W. Lanvale St., Ward

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57	51	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaking

(b) General nature of industry, business, or establishment in which employed (or employer) " 69

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Charles Cotton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Rose Wadell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Macon Cotton

(Address) Newark N. J.

15 Filed ..... 19.. Robert F. Garrison, Registrar

MAY 2 0 1924

Ruth Pratt Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17— 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1924, to May 17th, 1924, that I last saw h.. alive on May 17, 1924, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 9. mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. C.

Did an operation precede death? yes. Date of Dec. 13, 1923

Was there an autopsy? no

What test confirmed diagnosis? Agglutination

(Signed) Jas A Cathey, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greensboro N. C	May 20 1924
20 UNDERTAKER	ADDRESS V 26
Samuel Hensley	W Baltimore

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87152

90 D 87152

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 733 Mc Henry ST., 21 WARD)

2-FULL NAME Edward Miles Riley

(a) RESIDENCE NO. 733 Mc Henry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nellie Riley

6 DATE OF BIRTH (month, day, and year) July 8, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer Heinr Bruns

9 BIRTHPLACE (city or town) (State or country) Meridian, Miss.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Thomas Stowe

(Address) 710 N. Monroe St.

15 MAY 20 1924 Filed Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1924, to May 19, 1924, that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dan Cunningham, M. D.

5/19, 1924 (Address) 512 Hood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	May 21 1924
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87153

CERTIFICATE OF DEATH.

1903 V

1884 D 87153

1-PLACE OF DEATH, CITY OF BALTIMORE (No. 812 Ellwood Ave. WARD) 1

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L McKay

(Residence in Baltimore: No. 812 Ellwood Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Single

6-DATE OF BIRTH, December 20, 1882 (Month) (Day) (Year)

7-AGE, 41 yrs. 4 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer): Wm. Bacon 014

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: George McKay

11-BIRTHPLACE OF FATHER (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Bridget Higgins

13-BIRTHPLACE OF MOTHER (State or Country): Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bridget McKay

(Address) 812 E. Ellwood ave

15- Robert F. Harrison, ..., 191.....

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures and Con-

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Jos. Clinton Blades M.D. (Coroner.)

5/20/24 (Address) 143 W. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Patricks Cemetery

DATE OF BURIAL, 5/21 1924

20-UNDERTAKER, J. A. Moran

ADDRESS 322 E. Balto. St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V2 07824

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87154

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 87154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 106 N. Sixth St., Brooklyn Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel S Green

(a) Residence No. 106 N Sixth St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Green

6-DATE OF BIRTH (month, day and year) Oct 16 1854

7-AGE. 59 yrs. 7 mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) in B & O.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs Susie Green

(Address) 106 N Sixth st

15-

Filed 192

Robert P. Harrison, Registrar.

MAY 2 01924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 18-1924

17- I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to May 18, 1924.

that I last saw him alive on May 17, 1924.

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) yrs. 2 mos. ds

CONTRIBUTORY (Secondary) Dental infection, Rheumatism

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none except clinical finding

(Signed) M. E. Shannon M. D.

5/9/, 1924 (Address) 3300 W. Pratt Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill

DATE OF BURIAL. May 22, 1924

20-UNDERTAKER. John F Denny

ADDRESS 715 Light St

BE WRITTEN PLAINLY, with UNFADING INK. Every Answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Robinson 1307 N. Charles St ✓

D 87155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1516 Mt. Royal Ave St. 14 Ward) 74-09

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Nimmo

(a) Residence No. 1516 Mt. Royal Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliza B Robinson

6-DATE OF BIRTH (month, day and year) Oct 1. 1851

7-AGE. 72 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Collector

(b) General nature of Industry, business, or establishment in which employed (or employer) Collector Money 12

(c) Name of employer Various Companies

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. John E Nimmo

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER. Isabella Mungon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). England

11-(Informant) Sidney T. Nimmo

(Address) Towson Md

15-Filed MAY 20 1924 Robert F. Duffy, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 19 1924

17-I HEREBY CERTIFY, That I attended deceased from May 8 1924 to May 19 1924

that I last saw him alive on May 19 1924.

and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage
(3rd attack)

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Austin F. Robinson M.D.

5-20-1924 (Address) 1307 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lorraine	May 21, 1924
20-UNDERTAKER, Wm. Cook	ADDRESS 562 E Fayette Ave

Buried Forest Park.

WRITE PLAINLY, with unfading ink. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87156 ✓ D 87156

HEALTH DEPARTMENT—CITY OF BALTIMORE

51

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 937 N Chester St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Dvorala

(a) Residence No. 937 N Chester St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) — 1914

7-AGE. 10 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) School girl

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER. Vaclav Dvorak

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Bohemia

12-MAIDEN NAME OF MOTHER. Anna Zicek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Bohemia

14- (Informant) Vaclav Dvorak

(Address) 737 N Chester St.

15- Filed Robert P. Harrison, Registrar.

MAY 20 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 18/24

17- I HEREBY CERTIFY, That I attended deceased from May 16 1924 to May 18 1924

that I last saw her alive on May 18 1924

and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows:

Acute Tonsilitis

Acute Pulmonic Fever

Acute Endocarditis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Geo Burgess M. D.

May 19, 1924 (Address) 8 E Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Cross	May 21 1924
20-UNDERTAKER. Frank Crockson	ADDRESS 1906 Eutaw

WRITE PLAINLY, with unfading ink—This is very important. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87157

CERTIFICATE OF DEATH.

139 D 87157

REGISTERED NO.

1-PLACE OF DEATH Church Home - Infirmary

CITY OF BALTIMORE: (No. 1. Broadway ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie E. Dubel

(a) RESIDENCE NO. 1217 Hanover ST., WARD City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George G. Dubel

6 DATE OF BIRTH (month, day, and year) May 5, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George F. Dubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Annie Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant George G. Dubel

(Address) 1217 Hanover

15 Filed MAY 2 0 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to May 18, 1924, that I last saw her alive on May 18, 1924, and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

following

Operation for Multiple Myomata (Fibroid)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of May 15, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Cyprian Tarttelin, M. D.

, 19 (Address) Church Home and Dispensary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem—	May 22 1924
20 UNDERTAKER	ADDRESS
C. Schluraff & Son	Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 87158

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87158

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 E. 34th St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice D. Tucker

(a) RESIDENCE. No. 606 E 34th St., 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip D. Tucker

6 DATE OF BIRTH (month, day, and year) Aug 26th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Centerville Ind

PARENTS

10 NAME OF FATHER Henry M Driver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Sarah L. Maynard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Phillis L. Crossfield Daughter

(Address) 626 E. 34th St. City

15 [illegible] Robert E. [illegible] 19

Burial Permit Clerk Registrar

MAY 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1923, to May, 1924, that I last saw h[illegible] alive on May 18, 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation of heart.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no.

(Signed) E. E. Stickler Jr. M. D.

19 (Address) 632 Fawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	May 21 1924
20 UNDERTAKER	ADDRESS
E. Schlosman & Son	Hanover

THIS IS A PERMANENT RECORD. Every statement must be made in ink—THIS SIDE. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement must be made in ink—THIS SIDE. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87159 D 87159

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Scott St. 21 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Tacitus N. Halley

(Residence in Baltimore: No. 1008 Scott. St.; 60 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, January (Month) 5 (Day), 1850 (Year)

7-AGE, 74 yrs. 4 mos. 14 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Switchman
(b) General nature of industry, business, or establishment in which employed (or employer) ..... B. & O. R. R.

9-BIRTHPLACE, (State or Country) Clear Spring Md

PARENTS.

10-NAME OF FATHER, Tacitus Halley

11-BIRTHPLACE OF FATHER (State or Country), Frederick Md

12-MAIDEN NAME OF MOTHER Mary Lanahan

13-BIRTHPLACE OF MOTHER (State or Country) Clear Spring Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Kate Halley

(Address) 1008 Scott St.

15-

Filed ....., 1924. Robert F. Carrigan ..... Registrar.

MAY 20 1924 Burial Permit Alert

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 19 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan. 1924, to May 19 1924, that I saw h.m alive on May 18 1924, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

..... Nephritis Chronic .....

..... (Duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Senile Decay

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

5-20th, 1924 (Address) ..... St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cem — DATE OF BURIAL, 5-21, 1924

20-UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun & Hollins Sts

13.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87160

74-90 87160

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Lloyd ST., 3 WARD)

2-FULL NAME John B Finizzera

(a) RESIDENCE NO. 203 Lloyd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 13 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Finizzera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Margreth Morisco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Margreth Finizzera
(Address) 1203

15 MAY 20 1924 Robert P. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924 to May 19, 1924.

that I last saw him alive on May 18, 1924.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos 19 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. L. Perrazzo, M. D.

May 20, 1924 (Address) 9 Ten Hyes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincent — DATE OF BURIAL May 21 19

20 UNDERTAKER Wendell Apple's Son — ADDRESS 375 Ann

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87161

139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Resident

2-FULL NAME Mary Vrulturini

(a) RESIDENCE NO. Mt Hope Retreat ST., 25th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Unknown mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Vrulturini

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	63	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) (?) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country) Not Known

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed MAY 21 1924, 19 Robert P. Harrison, Registrar

Muriel Perrill Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16th 1891 to May 19th 1924, that I last saw her alive on May 18th 1924, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Fibrocystic Uterine Tumor (with degeneration)

abt (duration) 10 or 12 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Chronic Psychosis -

abt (duration) 33 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Sparrow's Point - Md -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 19th, 1924 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 21 1924

UNDERTAKER STERLING & BOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57

D 87162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secour Hospital ST., 20 WARD)

2-FULL NAME Francis de Sales Jenkins

(a) RESIDENCE NO. Bon Secour Hospital ST., 20 WARD Switzerland

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 4 ds. (at intervals) How long in U. S., if of foreign birth? 67 yrs. 3 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lowe Jenkins

6 DATE OF BIRTH (month, day, and year) Feb-18-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Austin Jenkins

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs E. Austin Jenkins (Address) Edmondson & Bruce Aves

15 Robert P. Harrison, Registrar

MAY 2 01924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12th, 1924, to May 20th, 1924, that I last saw him alive on May 20th, 1924, and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Purpura with secondary hemorrhage following operation

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Clin. & Lab. tests

(Signed) H. W. Powell, M. D.

5/29/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 22 1924
20 UNDERTAKER	ADDRESS
Stewart Mowen Company	108 W. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87163

122-09 87163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Orkney Rd. ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael P. Kehoe.

(a) RESIDENCE No. 508 Orkney Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine M. Byrne.

6 DATE OF BIRTH (month, day, and year) — — 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Michael Kehoe.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) 508 Orkney Rd

MAY 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1924

17 I HEREBY CERTIFY, That I attended deceased from May-11, 1924, to May-19, 1924,

that I last saw him alive on May 19, 1924,

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hocas. M. D.

5-20 1924 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 5/27 1924

20 UNDERTAKER J. Schaefer & Sons

ADDRESS 316 E. Lafayette

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87164

CERTIFICATE OF DEATH.

90

D 87164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5718 Park Heights Ave ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Louis Hoos

(a) RESIDENCE. No. 5718 Park Heights Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Barbara Sophia Hoos.

6 DATE OF BIRTH (month, day, and year) Sept 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Stewart & Co

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hoos.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa Schultz

13 BIRTHPLACE OF MOTHER (city or town) Weisenbach
(State or country) Germany

14 Informant John Henry Louis Hoos.
(Address) 5718 Park Heights Ave

15 Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/24 19

17 I HEREBY CERTIFY, That I attended deceased from 3/10/24, 19..., to May 19 24, 19..., that I last saw him alive on May 19/24 5-30 19..., and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis Edema

(duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Adolph Hoos M. D.

5/19/24 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 24
UNDERTAKER	ADDRESS
H B Hupfeld	2236 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL items should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87165

D 87165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 So Pulaski ST. 20th WARD)

REGISTERED NO. 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary Wagner

(a) RESIDENCE NO. 313 So. Pulaski ST. 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A. Wagner

6 DATE OF BIRTH (month, day, and year) Sept 29th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. H. Albiker

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Schroder

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Joseph A. Wagner
(Address) 313 So. Pulaski St.

15 Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain—
Suicide by Pistol shot in head
(duration) at once yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)
May 19th 1924 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 21 1924
UNDERTAKER	ADDRESS
H. B. Hoppert	2336 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87166

CERTIFICATE OF DEATH.

90 D 87166

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1520 McElderry St ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora McKeever

(a) RESIDENCE NO. 1520 McElderry ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 18) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Mckeever

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Matt Whitaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Martha Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant John McKeever
(Address) 1520 McElderry St.

15 MAY 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Maty 19/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valv. Insufficiency-
Endocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... , M. D.
(Coroner.)

May 20/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dublin cemetery

DATE OF BURIAL mar 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans

Spec.—8-24-14—M. & T.—2000 Blks.

D 87167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87167

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes C Walger

(Residence in Baltimore: No. 900 N. Monroe St St. Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	W	W

6-DATE OF BIRTH. Aug 16, 1861 (Month) (Day) (Year)

7-AGE. 63 yrs. 9 mos. ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER Louis C Walger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Caroline M LaPorte

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wallace J Walger

(Address) 900 North Monroe

15- MAY 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 29 1924, to May 19 1924, that I saw her alive on May 19 1924, and that death occurred, on the date stated above, at 8 P. m. The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. — mos. — ds.

(Signed) Wilbur F Fiellman M. D.

May 20, 1924 (Address) 6 E Biddle St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 1 mos. 17 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 900 North Monroe

Former or usual residence 900 North Monroe St.

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, May 21, 1924

20-UNDERTAKER Wm. Cook — ADDRESS 502 E Northern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87168

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1146 W. Hamburg ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Miller

(a) RESIDENCE NO. 829 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Miller

6 DATE OF BIRTH (month, day, and year) April 14 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... Home 37

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Schmelz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise R. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs. Louise Schmelz 1146 W. Hamburg St.

15 Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1924, to May 18th, 1924, that I last saw her alive on May 18th, 1924, and that death occurred, on the date stated above, at 10 50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. — mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 829 W. Cross St.

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Harry Kleibel, M.D.

19, 1924 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 22 1924

20 UNDERTAKER	ADDRESS
William Cook	502 E. N. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37169

CERTIFICATE OF DEATH.

91-002

D 37169

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Queen Anne Road ST.) 15 WARD)

2-FULL NAME Louise T. Stanloff

(a) RESIDENCE. NO. 8 Queen Anne Rd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 - 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Librarian 086

(b) General nature of industry, business, or establishment in which employed (or employer) Pratt's Library

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Carl F. Stanloff

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Lentz

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant C. V. Stanloff
(Address) 8 Queen Anne Rd

MAY 21 1924 ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1924, to May 19th, 1924, that I last saw her alive on May 19th, 1924, and that death occurred, on the date stated above, at 4.15 p m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Auto-toxaemia Arteriosclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Dr W. Krown, M. D.

5/20/1924 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 22 1924
20 UNDERTAKER	ADDRESS
Chas. E. Franck	502 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-24 M&T 1500 Bks.

1204

P 87170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 87170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME William Poole

(a) RESIDENCE NO. 1401 Virginia ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 25 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Roland Poole

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Anita Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 MAY 21 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to May 20, 1924, that I last saw h... alive on May 20, 1924, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 25 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thos. R. Brown, M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	May 21 1924
20 UNDERTAKER Joseph J. Cowan & Son	ADDRESS 1 E Lexington St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1469 D 87171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Carrollton Ave WARD)

2-FULL NAME Dorothea E. Tisdale

(a) RESIDENCE No. 1102 N. Carrollton Ave STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 20 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John T. Tisdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucile Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ft. Mansfield W. Va.

14 Informant Lucile Tisdale

(Address) 1102 N. Carrollton Ave

15 Filed MAY 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14 — 1924, to May 20 1924

that I last saw h[illegible] alive on May 19 — 1924

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Childbirth

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Coleman M. D.

(Address) 2039 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	May 22 1924
20 UNDERTAKER	ADDRESS
Wm. B. G. Elliott	1727 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87172

CERTIFICATE OF DEATH.

89 D 87172

1-PLACE OF DEATH

City of BALTIMORE, (2341 Eutaw Place St., 19 Ward)

Registered No.....

(If death occurred in a hospital, or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Sandigursky

(a) Residence No. 2341 Eutaw Place St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	W	M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Sandigursky

6-DATE OF BIRTH (month, day and year) December

7-AGE. 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Yischel Sandigursky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Rasel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15- Filed MAY 21 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-20-24

17- I HEREBY CERTIFY, That I attended deceased from May 9- 1924 to May 20 1924

that I last saw him alive on May 20 1924

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart -

(Duration) yrs. mos. 30 min.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Robert T. Litchfield M. D

May 21, 1924 (Address) 1117 Mercantile Bldg

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19
Hebrew Rit Cemetery	May 22
20-UNDERTAKER	ADDRESS
Jack Lewis,	1439 E. Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87173

CERTIFICATE OF DEATH.

90 D 87173

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2807 Fait Ave ST., 1 WARD)

2-FULL NAME Barbara Gardelin

(a) RESIDENCE NO. 2807 Fait Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 5 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frederick Gardelin

6 DATE OF BIRTH (month, day, and year) Mar 13/64 Jaquery

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER John Beissman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Gardelin
(Address) 2807 Fait av

Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquery (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regur.

Exhaustion (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos C. Staden, M. D.
5/20/24 192 (Coroner) (Address) 143 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartzem

DATE OF BURIAL 5/21 1924

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87174

CERTIFICATE OF DEATH.

74-09 D 87174

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 536 N. Milton Av St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Davids

(a) Residence No. 536 N. Milton av St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: late Henry B. Davids

6-DATE OF BIRTH (month, day and year): Sept 2/58

7-AGE: 65 yrs. 8 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): City

PARENTS.

10-NAME OF FATHER: Sterner

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md.

14- (Informant): Harry P. Davids

(Address): 539 N. Milton

15- Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 5/19/24

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924 to May 19 1924

that I last saw h.. alive on May 19 1924

and that death occurred, on the date stated above, at 1 30 M. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert L. Green M. D

5-20-1924 (Address) 120 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Pk.	5/22 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Orleans

I. S. WHITE PRINTING CO., BALTIMORE, MD. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87175

CERTIFICATE OF DEATH.

90 D 87175

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1367 N. Carey St. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maregret Ellen Downs

(a) RESIDENCE NO. 1367 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Horace Downs

6 DATE OF BIRTH (month, day, and year) Jan. 26-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Nimrod Downs

(Address) 1613 E. Mulberry

MAY 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 15 1924 to May 19 1924.

that I last saw h[illegible] alive on May 18 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James W. Thayer M. D.

5/19. 1924 (Address) 513 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: WM Auburn — DATE OF BURIAL: May 21 1924

20 UNDERTAKER Wm. H. Chase & Son — ADDRESS 1401 Mad[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87176

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 87176

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. U.S. Marine Hosp. St.: 12 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John Erickson

(Residence in Baltimore: No. U S Marine Hospital St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Sigle

6-DATE OF BIRTH, ..., 1.....
(Month) (Day) (Year)

7-AGE, 63 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Sweeden

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) U S Marine Hosp

(Address).....

15- Filed MAY 21 1924 19.. ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 19, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH was as follows:

Cardiac Disease
Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John H Mountcastle M. D.
(Coroner.)

May 20 1924 (Address) 3692 Roland Ave

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

For.....

Former or usual residence Unknown

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Trinity Cemetery	5/21....., 19..
20-UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No.) 3326 Myrtle Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Brady

(a) Residence No. 3326 Myrtle Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
F.	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John F Brady

6-DATE OF BIRTH (month, day and year) Dec 25-1871

7-AGE	If LESS than 1 day,
52 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Carl Gorman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, " " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14- (Informant) John F. Brady
(Address) 3326 Myrtle Ave

15- MAY 21 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 19-1924

17- I HEREBY CERTIFY, That I attended deceased from July 1- 1923, to May 19- 1924,
that I last saw h.. alive on May 18 1924,
and that death occurred, on the date stated above, at 3 30 a m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Allen C Beecham, M. D.
May 19, 1924 (Address) 3139 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Dark Lane Cemetery	May 23 1924

20-UNDERTAKER, Robt E Turner — ADDRESS 47 E Pratt

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87178

CERTIFICATE OF DEATH.

101 D 87178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 Sterett St. 21 WARD)

2-FULL NAME Margaret E Hartman

(a) RESIDENCE No. 1013 Sterett St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Hartman

6 DATE OF BIRTH (month, day, and year): July 25. 1898.

7 AGE: Years 25. Months 9 ~~10~~ Days 25. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home duties

(c) Name of employer: -

9 BIRTHPLACE (city or town) (State or country): Washington DC

PARENTS

10 NAME OF FATHER: Thos. Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md. US

12 MAIDEN NAME OF MOTHER: Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Illinois

14 Informant (Address): Carl Hartman 1013 Sterett St

15 Filed MAY 21 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May. 19 1924

17 I HEREBY CERTIFY, That I attended deceased from May. 16. 1924. to May. 19. 1924.

that I last saw h[illegible] alive on May. 19. 1924

and that death occurred, on the date stated above at 10.15 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos ✓ ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Finnegan, M. D.

5/20 1924 (Address) 1001 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 22 1924

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1005 S Paca St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87179

74-001

D 87179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Washington Blvd. ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sigourney C. Proctor

(a) RESIDENCE NO. 810 Wash. Blvd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard C. Proctor

6 DATE OF BIRTH (month, day, and year) Apr 17 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. G. Downes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Digler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Richard C. Proctor

(Address) 810 Wash. Boulevard

15 Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 20 19 24

17 I HEREBY CERTIFY, That I attended deceased from 11. 18. 23, 19..., to 5. 20. 24, 19...,

that I last saw h-- alive on 5. 16. 24, 19...,

and that death occurred, on the date stated above, at 9. a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 3/2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical. B. M. Examination

(Signed) Phillip B. Fowler, M. D.

5. 20. 24 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Port Republic Va	May 25 19 24
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87180

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 87180

101-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Whatcoat ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Banks

(a) RESIDENCE. No. 809 Whatcoat ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Nov 5, 1898

7 AGE — Years: 26 — Months: 2 — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Alfred Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Harriet Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Harriet Banks 809 Whatcoat

MAY 21 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12 1924 to May 18 1924

that I last saw him alive on May 18 1924

and that death occurred, on the date stated above, at 855 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. B. Lurie, M. D.

May 18 1924 (Address) with Dr. Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	5-21 1924
20 UNDERTAKER	ADDRESS
Daniel Easton	916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may, be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87181 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87181

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2207 Christian St., 20 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rettner

(a) Residence No. 2207 Christian St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Peter Rettner

6-DATE OF BIRTH (month, day and year): Oct 10-1857

7-AGE: 66 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): At home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Buffalo Ind.

PARENTS.

10-NAME OF FATHER, John J. Becker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Peter Rettner

(Address) 2207 Christian St

MAY 21 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 19-24

17- I HEREBY CERTIFY, That I attended deceased from May 8 1924 to May 19 1924

that I last saw h alive on May 19 1924

and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arteriosclerosis

Acute Dilatation

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Endocarditis Pulmonary

Pertussis (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert R. Krauter M. D

5/20/24 (Address) 2150 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL, May 22 1924

20-UNDERTAKER: George L. Schmidt — ADDRESS: 1161 Fulton Ave.

This is a CERTIFICATE OF DEATH. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87182

HEALTH DEPARTMENT—CITY OF BALTIMORE

163 D 87182

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mildred Wissner

(a) RESIDENCE NO. 137 South 5th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Wissner

6 DATE OF BIRTH (month, day, and year) Nov 17/1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Clifton Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna V. McQuay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Lilly and Zeiler
(Address) 403 S Wolfe St

15 MAY 21 1924 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May20/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Paul, M. D.
(Coroner.)

May 21/24 (Address) 508 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Hill Cem.	5/22 1924
20 UNDERTAKER	ADDRESS
Lilly - Zeiler	403 S Wolfe St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 87183

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 217 N Gunley St. 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J Doll

(a) Residence No. 217 N Gunley St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND ~~of (or)~~ WIFE of Dorothy Doll

6-DATE OF BIRTH (month, day and year) Dec 27 1885

7-AGE,	If LESS than 1 day,
38 yrs. 4 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook Binder

(b) General nature of industry, business, or establishment in which employed (or employer) 164

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore City
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER Adam Doll

11-BIRTHPLACE OF FATHER (city or town) German
(State or Country)

12-MAIDEN NAME OF MOTHER Louisa Gunson

13-BIRTHPLACE OF MOTHER (city or town) German
(State or Country)

14- (Informant) Dorothy Doll

(Address) 217 N. Gunley St.

MAY 2 1 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 19 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to May 19 1924

that I last saw him alive on May 12 1924

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

..... 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Findings

(Signed) Geo Clinton Bloodd M. D.

5/21/24 (Address) 436 Fenway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	May 22 1924
20-UNDERTAKER, Tilly & Geiler	ADDRESS 403 S. Wolfe St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

87184

HEALTH DEPARTMENT—CITY OF BALTIMORE

87184

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 17 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Dorsey

(a) RESIDENCE. No. 704 Bruce St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Dorsey

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Lucinda Johnson

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Municipal Hospital Record

(Address)

15 [illegible]

MAY 21 1924

ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1924

17

I HEREBY CERTIFY, That I attended deceased from 5-12, 1924, to 5-20, 1924

that I last saw him alive on 5-20, 1924

and that death occurred, on the date stated above, at 10^20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia; Bronchopneumonia (Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. + Autopsy

(Signed) Claude S. Drake, M. D

5-20 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-23 1924
20 UNDERTAKER	ADDRESS
Helen A. Holland	1031 Wilkens Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87185

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1014 Roland Heights Ave. Sta. 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Edith E. Dorsey

(a) Residence No... 1014 Roland Heights Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George A. Dorsey

6-DATE OF BIRTH (month, day and year) April 26-1874

7-AGE. 50 yrs. — mos. 24 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Baltimore Co. Md

PARENTS.

10-NAME OF FATHER, Isaac Freeland

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Nancy Bosley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant)... George A. Dorsey

(Address)... 1014 Roland Hgts. Ave

15-

Filed... Robert P. Harrison, Registrar.

MAY 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 20-1924

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1924 to May 20, 1924 that I last saw h.. alive on May 19, 1924 and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Malignant Growth of Throat & Tongue

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorhages & debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Hattie E. Nickman, M. D.

5/21. 1924 (Address) 2002 N. Fremont

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western	May 22. 1924
20-UNDERTAKER	ADDRESS
Horace F. Burgee	363 Fallo Road

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87186

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3311 Guilford ave ST., 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura J. Ford

(a) RESIDENCE NO. 3311 Guilford ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John D. Ford

6 DATE OF BIRTH (month, day, and year): Sept. 27-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City Md.

PARENTS

10 NAME OF FATHER: John Darling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Catherine Heden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: A. Faith Ford

(Address) 3311 Guilford ave

AY 2 1924 Robert E. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 4, 1924, to date of death, that I last saw her alive on May 20, 1924, and that death occurred, on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:

Death was due to Cerebral Hemorrhage

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Emerson Lee Davis, M. D.

May 21 '24 (Address) 814 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	May 22 1924
20 UNDERTAKER	ADDRESS
Wm C. Black	927 N. Broadway

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37187

CERTIFICATE OF DEATH.

129 D 37187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Ensor ST. 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Theresa Jacobs

(a) RESIDENCE. NO. 1117 N. Ensor ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Jacobs

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Patrick Rooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine M McCartney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John A Jacobs

(Address) 1117 N Ensor St

15 Filed MAY 21 1924, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-19- 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 19, 1924, that I last saw her alive on May 19, 1924, and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) Jane Miller, M. D.

, 19 (Address) 1536 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross, Harford Road	May 22 1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fayette

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87188

D 87188

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 907 Ridgely St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Hart

(a) Residence No... 907 Ridgely St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis B Hart

6-DATE OF BIRTH (month, day and year) Feby 29 1480

7-AGE. 44 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Henry Rudolph

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Franken

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Louis B Hart

(Address) 907 Ridgely St

15- Filed MAY 21 1924 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 20 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 20, 1924, that I last saw h[illegible] alive on May 19, 1924, and that death occurred, on the date stated above, at 12 00 noon m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) J. Whitridge Hoen M. D.

May 24 1924 (Address) 712 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. May 23, 1924

20-UNDERTAKER. Wilhelm Bros & Nadler

ADDRESS

Burial Permit Clerk

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87189

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09 D 87189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 Oak ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude H. Singleton

(a) RESIDENCE NO. 1730 Oak ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE Years 24 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Singleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary C. Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Gertrude Singleton

(Address) 1730 Oak St

AY 21 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from April 12 , 1924 , to May 20th , 1924 ,

that I last saw her alive on May 19th , 1924 ,

and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Jennie M. Brown M. D.

, 1924 (Address) 1233 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 5/22 1924

20 UNDERTAKER J. F. Carey Sons

ADDRESS 1318 Eutaw St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. *AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87190 31 D 87190

CERTIFICATE OF DEATH.

1-PLACE OF DEATH /

CITY OF BALTIMORE: (No 1922 McCulloh ST. 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Colvin Wilson

(a) RESIDENCE. No. 1922 McCulloh ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alberta Wilson

6 DATE OF BIRTH (month, day, and year) June 6-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer N. B. Loeb.

9 BIRTHPLACE (city or town) (State or country) Middlepost Virginia

PARENTS

10 NAME OF FATHER James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nat Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Alberta Wilson
(Address) 1922 McCulloh st

15 Filed MAY 21 1924 19 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1924, to May 16th, 1924, that I last saw h... alive on May 15. 1924, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No ~~Post mortem examination~~

What test confirmed diagnosis? Clinical findings

(Signed) Russell Fanga, M. D.

, 19 (Address) 2937 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	19
20 UNDERTAKER Samuel J Kennedy & Bro	ADDRESS 578

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87191

CERTIFICATE OF DEATH.

31 D 87191

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hosp. St. 7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles McQuay

(a) RESIDENCE. No. 907 St Paul St. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles McQuay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha Hann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Fannie McQuay (Address)

15 Filed MAY 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26 1924, to May 9, 1924, that I last saw h[illegible] alive on May 19, 1924, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Cavitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) J Cyril Ebey, M. D.

, 19 (Address) 1520 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	May 22 19 24
20 UNDERTAKER: Samuel T Kemsley	ADDRESS: 1 Biddle

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should supply information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87192

CERTIFICATE OF DEATH.

D 87192

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hotel Condon Fayette Place St. ST.; 15 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Mary E Adler.

(Residence in Baltimore: No. 3713 Park Heights Ave. St. Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F.	W.	Widow

6-DATE OF BIRTH, 7 (Month) 21 (Day), 1847 (Year)

7-AGE, 76 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Work
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore Md. U. S.

PARENTS.

10-NAME OF FATHER, John Kitken

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Smith

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aaron Adler

(Address) 2453 Barclay

15-

Filed MAY 22 1924, 191.. ROBERT R. KRAUTER, Registrar.

MAY 22 1924 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 20 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/20/24 191.., to 5/20/24 191..., that I saw her alive on 5/14/24 191..., and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) S W Gudder M. D.

5/20/24, 191... (Address) 321 E-25

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. 5 mos. — ds. In the State Life yrs. mos. ds.

Where was disease contracted, if not at place of death? ✓

Former or usual residence 3712 Park Heights Ave.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park	May 22, 191..

20-UNDERTAKER	ADDRESS
J. Adkins & Co	16 N Mad ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87193

CERTIFICATE OF DEATH Roseberg 74-001 D 87193

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin + Sippel Ave. Belair Rd. Md ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Sippel

(a) RESIDENCE No. Franklin + Sippel Ave's ST., Rospeburg WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Sippel

6 DATE OF BIRTH (month, day, and year) March 15th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John Sippel

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant John Sippel (Address) Rideleth Md.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923 to May 20. 1924.

that I last saw him alive on May 20. 1924.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

Chronic Bright Disease (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease + Complication Disease (duration) yrs. 11 mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. Kennard, M. D.

5-20 1924 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jewish Cemetery DATE OF BURIAL May 23 1924

20 UNDERTAKER Fredk Lasch & Sons ADDRESS Fullerton

1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 1 0 01 D 87194

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1041 Harford Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Sobin

(a) Residence No. 1041 Harford Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John J. Sobin

6-DATE OF BIRTH (month, day and year) about 1854

7-AGE, Years 70 yrs. 0 mos. 0 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Not Known Hogan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. John J. Sobin

(Address) 1041 Harford Ave

15- MAY 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 20 1924

17- I HEREBY CERTIFY, That I attended deceased from May 13, 1924, to May 20, 1924, that I last saw h-r alive on May 20, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) Unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jefferson Bunch M. D.

(Address) May 21, 1924 2846 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL, May 14 24

20-UNDERTAKER E. W. Conklin ADDRESS 924 E. Fayette St.

WHITE PAPER, WITH PRINTING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 87195

Harps

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 87195

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital Registered No.....

City of BALTIMORE: (No..... St., 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Aline Harps

(a) Residence No. 654 W. Mulberry St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Blk

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1875

7-AGE, 49 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None. did

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore City

PARENTS.

10-NAME OF FATHER, Moses Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Bay View Hospital

(Address) Baltimore, Md.

15- Filed MAY 22 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/21/24

17- I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 20, 1924, that I last saw her alive on May 20, 1924, and that death occurred, on the date stated above, at 6.15a m.

The CAUSE OF DEATH* was as follows:

Genial Paralysis of the Insane

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Microscopical findings.

(Signed) D. F. Arnold M. D.

. 19 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn Cem	5-16-1924
20-UNDERTAKER, Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87196

CERTIFICATE OF DEATH.

31 D 87196

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Pitts, St., 12 WARD)

2-FULL NAME Douglas Reuben

(a) RESIDENCE NO. 2462 E. 7th, ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Reuben

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Public Sch

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Reuben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rose Reuben (Address) 1407 Pitts St

15 Filed MAY 24 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15th 19 24 to May 20th 1924

that I last saw h.. alive on May 17th 1924

and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis,

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Chis M. D.

May 21, 1924 (Address) 924 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-23 1924

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 708 Georgetta St., 4 Ward)

Registered No. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Edward Ringold

(a) Residence No. 317 Myrtle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1889

7-AGE. 35 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). 0

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Mrs. Ruby Howard

(Address) 312 Myrtle ave

15- Filed MAY 2 1924 ROBERT R. KRAUSE Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/19/24

17- I HEREBY CERTIFY, That I attended deceased from 8/17, 1923 to 5/19, 1924, that I last saw h.. alive on 5/19, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 3 yrs. 10 mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an antopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jorgan J Burton, M. D.

, 19 (Address) 32 19 Penn ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Port Auburn Cem

DATE OF BURIAL, 5-22-24

20-UNDERTAKER. James Easton

ADDRESS 916 Pa ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87198 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87198

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 14 WARD)

REGISTERED NO. 199

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. F. Kenner

(a) RESIDENCE No. 537 Mc. Mechen St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32 yr.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Kenner

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Weaver

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary Kenney
(Address) 1714 E. Fairmount Ave

15 Filed MAY 22 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Cl...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to fracture of skull. Fell on lead weight, Laundry, (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Accident (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)
May 21, 1924 (Address) 2 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	May 22 1924
20 UNDERTAKER Mrs. R. C. Allen	ADDRESS 1217 Lanvale St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 87199 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87199

CERTIFICATE OF DEATH.

165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johannah Mabel Johnson

(a) RESIDENCE NO. 131 4th St. Brooklyn Md. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Herbert E. Johnson

6 DATE OF BIRTH (month, day, and year) Feb15/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer at home

D 37

9 BIRTHPLACE (city or town) Curtis Bay
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Reddish

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Amelia Malone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Herbert E.Johnson
(Address) 131 N. 4th St Brooklyn Md

15 MAY 2 2 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bichloride Mercury Poisoning-
Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Waller, M. D.
(Coroner.)

May 21/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	May 24 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87200

90 D 87200

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Light St. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George S. Moyer.

(a) RESIDENCE No 828 Light St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ---- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced
HUSBAND of
Ray Moyer.

6 DATE OF BIRTH (month, day, and year) June 3 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Window cleaner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer National Window Clng. Co.

9 BIRTHPLACE (city or town) (State or country) Allentown Pa.

PARENTS

10 NAME OF FATHER John Moyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliza Fenstermacher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Ray Moyer, (wife)
(Address) 426 Broadway Gloucester N. J.

15 MAY 22 1924 ROBERT R. KRAUTER Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute dilatation of the Heart with Acute Gastritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

May 21, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem'y Md	May 22 1924
20 UNDERTAKER	ADDRESS
John F Denny.	715 Light St

If DEATH occurred in a hospital or institution, the certificate should be filled out and signed by the Superintendent or his authorized representative, and the patient's residence given. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D 87201

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-007 D 87201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home Infirmary

CITY OF BALTIMORE: (No. N. Broadway ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Gold

(a) RESIDENCE NO. 4103 Liberty Heights Ave ST., WARD City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas L. North

6 DATE OF BIRTH (month, day, and year) Jan 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House - wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Begnelle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Hannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Thomas L. North

(Address) 4103 Liberty Heights Ave

15 Filed MAY 2 2 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1924, to May 20, 1924,

that I last saw h[illegible] alive on May 20, 1924,

and that death occurred, on the date stated above, at 5:40 m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

Adhesions

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of [illegible]

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Reynold Brothers, M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 23 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Steuman (Stirman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87202

CERTIFICATE OF DEATH.

74-001

D 87202

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Pennsylvania Ave ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Stirman

(a) RESIDENCE NO. 932 Penna ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Stirman

6 DATE OF BIRTH (month, day, and year) June 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) Oth

(c) Name of employer Lyric Theatre

9 BIRTHPLACE (city or town) (State or country) Baltimore city Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Abe +

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Helen Stirman

(Address) 932 Penna ave

15 MAY 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1924

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1924, to May 22, 1924.

that I last saw him alive on May 22, 1924.

and that death occurred, on the date stated above, at 6, 22 m.

The CAUSE OF DEATH* was as follows:

Ap Polyneuritis Cerebral Hemorrhage.

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Ch. Pneumonia

(duration) ... yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home of wife

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical Exam

(Signed) Walter L. Johnson, M. D.

, 19 (Address) 1618 W. Fairmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	5/23 1924
20 UNDERTAKER Byron Wright	ADDRESS 1218 McCulloh St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—E.B.R.B.—400 Lks.

87203

HEALTH DEPARTMENT—CITY OF BALTIMORE

87203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3138 O'Donnell St. St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip T. Mareski

(a) Residence No. 3138 O'Donnell St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the Word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): May 24-1900

7-AGE. 23 yrs. 11 mos. 27 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS

10-NAME OF FATHER: Mareski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Stanislawa

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-

(Informant) Wife Mareski

(Address) 3138 O'Donnell St

15-

MAY 22 1924

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 20-1924

17- I HEREBY CERTIFY, That I attended deceased from May 12th 1924 to May 20th 1924

that I last saw him alive on May 20th 1924,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

From Family History

(Duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) DeTorrell M. D

5/22/1924 (Address) 1011 N. Edwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem

DATE OF BURIAL: May 23, 1924

20-UNDERTAKER: Stephen J. Kaikowski

ADDRESS: 1011 Edwood ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Weintzer

D 87204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87204

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Mentzer

(a) RESIDENCE NO. 1385 W. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Jacob Mentzer

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant Hospital Record (Address)

15 MAY 22 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/24

17 I HEREBY CERTIFY, That I attended deceased from 3/8/24, 19..., to 5/21/24, 19... that I last saw h alive on 5/21/24 and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carbuncle Back

Carbuncle (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Hellen, M. D.

, 19 (Address) Mercy H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	5/22 19 24
20 UNDERTAKER	ADDRESS
Jack Levin	1439 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 87205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 N Pulaski St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Regina Fishel

(a) RESIDENCE NO. 1707 N Pulaski ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Fishel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	~	~	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Yostell Kallman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Celia ~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 Filed MAY 21 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1924, to May 21, 1924, that I last saw her alive on May 21, 1924, and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (right) 1 yr

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Cahn, M. D.

5/24. 1924 (Address) 2105-11 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 5-24 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87206 ✓ D 87206

CERTIFICATE OF DEATH.

D 87206

1-PLACE OF DEATH

Registered No. 90

City of BALTIMORE: (No. 1431 Cookson St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vladek Plastinsky

(a) Residence No. 1431 Cookson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Plastinsky

6-DATE OF BIRTH (month, day and year) March 17, 1882

7-AGE. 42 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steerdor 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Warsaw Poland Europe

PARENTS.

10-NAME OF FATHER, Ludislav Plastinsky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14-(Informant) Anna Plastinsky

(Address) 1431 Cookson

15- MAY 22 1924 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 21-24

17- I HEREBY CERTIFY, That I attended deceased from April 10 19 24 to May 21 19 24

that I last saw h[illegible] alive on May 20 24

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart 4 hrs.
Mitral Regurgitation

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. 1 mos. 11 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos H Stevens M. D

5/21, 1924 (Address) 2878 Hayford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	May 23 1924
20-UNDERTAKER.	ADDRESS
Burkler Burkler	Eager

R. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1718 D 87207 — 1729 D 87207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 7 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dena Forster

(a) RESIDENCE NO. Vero, Florida WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Forster

6 DATE OF BIRTH (month, day, and year) June 15, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	46	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER William Hegewisch

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Heits

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ....., 19 .... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MAY 22 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 21, 1924, that I last saw h.. alive on May 21, 1924, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen, M. D.

May 22 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brooklyn N. Y.	May 22 1924

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 2499

City of BALTIMORE: (No. 1110 William St., St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia M. Boerner

(a) Residence No. 1110 William St., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 15 1923

7-AGE.	If LESS than 1 day,
yrs. 8 mos. 6 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) Balto. Md. (State or Country),

PARENTS.

10-NAME OF FATHER. George H. Boerner

11-BIRTHPLACE OF FATHER (city or town) Brunswick Md. (State or Country).

12-MAIDEN NAME OF MOTHER. Agnes Brickner

13-BIRTHPLACE OF MOTHER (city or town) York Pa. (State or Country).

11- (Informant) George H. Boerner

(Address) 1110 William st.

15- MAY 22 1924

12- ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 21, 1924.

17- I HEREBY CERTIFY, That I attended deceased from May 1/24 19 to May 21/24 19

that I last saw her alive on May 20/24 19

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

2 hrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis & Pneumonia

1 mo (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? H

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Kolb M. D

, 19 (Address) 103 Eight Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cem	5/24 1924
20-UNDERTAKER.	ADDRESS
J. F. McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87209 D

65-001 ✓

D 87209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2015 Edgewood Av REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2015 ST.; Edgewood Av WARD 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hugh Simms

(Residence in Baltimore: No. 2015 Edgewood Av St.; 35 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word.) Married

6-DATE OF BIRTH, July 23, 1878 (Month) (Day) (Year)

7-AGE, 46 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: asst. Treas. Central
(b) General nature of industry, business, or establishment in which employed (or employer): Savings Bank

9-BIRTHPLACE, (State or Country) Edgewood Pa

PARENTS.

10-NAME OF FATHER, Geo. A Simms

11-BIRTHPLACE OF FATHER (State or Country) Edgewood Pa

12-MAIDEN NAME OF MOTHER Mary Combs

13-BIRTHPLACE OF MOTHER (State or Country) Edgewood Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H D Simms

(Address) 3325 Mt Ave

MAY 22 1924 Filed ..... 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5/21/1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 15 1924, to May 21 1924, that I saw him alive on May 21 1924, and that death occurred, on the date stated above, at 6-30 a m.

The CAUSE OF DEATH* was as follows:

Splenic Myelogenous Leukemia

(Duration) 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. G. Queen M. D.

5/22, 1924 (Address) 3501 Garrison Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, May 25, 1924

20-UNDERTAKER George J Smith — ADDRESS 1532 Hollins St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87210 ✓ D 87210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Kate Ave ST. 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ellsworth Whalen

(a) RESIDENCE. NO. 2603 Kate Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Ellsworth Clarence Whalen

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Chapman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md
(State or country)

14 [illegible] E C Reed M.D.
[illegible] 3

MAY 22 1924
Burial Permit Cert. No.
NUGENT, Registrar

15 Filed . 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1924

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to May 22, 1924, that I last saw h[illegible] alive on May 21, 1924, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. R. V. Clift M. D.

5/22 1924 (Address) 1312 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 22 1924
20 UNDERTAKER Jos. H. Bloom	ADDRESS 1003 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87211

CERTIFICATE OF DEATH.

100-001 ✓

D 87211

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. 1012 Gilmor St.: 16 WARD)

2-FULL NAME Baby Edith Forrest

(a) RESIDENCE. No. 1012 Gilmor St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 25th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER James Edw. Forrest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Geo. Co., Md.

12 MAIDEN NAME OF MOTHER Pauline M. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City New York

14 Informant Jas. Edw. Forrest (Address) 1012 Gilmor

15 MAY 22 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19th 1924, to May 21st 1924, that I last saw her alive on May 21st 1924, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jos. E. Bell M. D.

(Address) 1124 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 23 1924
20 UNDERTAKER	ADDRESS
Sam'l. H. Chase & Son	1400 Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1060 Bks.

D 87212

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87212

88

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 S. Third St. ST.: 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Kreppel.

(a) RESIDENCE. NO. 510 S. Third St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick T. Kreppel.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara Fox

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Frederick T. Kreppel.
(Address) 510 S. Third St.

15 Filed Robert L. Morris, Registrar

MAY 22 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1924, to May 20, 1924, that I last saw her alive on May 20, 1924, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Chorea

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Ant. Endocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank A. Hearty, M. D.

5/22, 1924 (Address) 324 E Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	May 23 1924
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	603 S. Wolfe St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87213 × 3 ✓ D 87213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Groot

(a) RESIDENCE No. Churchton Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
68	"			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Churchton
(State or country) Md.

PARENTS

10 NAME OF FATHER Jon Groot

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Coats

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant
(Address) Son Churchton

15 Filed AY 22 1924 Robert P. Harrison, Registrar

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/6/ 1924 to 5/21 1924

that I last saw he alive on 5/21 1924

and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculosis Bacillus

(duration) 9. yrs. mos. ds.

CONTRIBUTORY
(Secondary) Circulatory System (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 5/17/24

Was there an autopsy? No

What test confirmed diagnosis? Sputum Lab Hyg

(Signed) R. G. Ed M. D.

. 19 (Address) Md Univ Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shady Side Md Cross Cemetery a.a.co.

DATE OF BURIAL May 24 1924

20 UNDERTAKER B L Hopkins

ADDRESS Annapolis

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~D~~ 87214

90 D 87214

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 246 S. Caroline ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Alexander

(a) RESIDENCE NO. 246 S. Caroline ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Saddie Alexander

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	approx 29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Saddie Alexander (wife)
(Address) 246 S. Caroline

15 MAY 22 1924 Robert F. Carrick
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to May 20, 1924, that I last saw h alive on May 18, 1924, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Ruth, M. D.

Oct. 24, 1924 (Address) 1429 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL May 23 1924

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harlem

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN'S mation, should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

2117 Md Ave Dr Arthur Wallace

Spec. 6-9-19 H. P. Co. 1000 Blks.

D 87215

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87215

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 103 E 25th St.: W (WARD)

2-FULL NAME Charles H. McClure

(a) RESIDENCE. No. 103 E 25th ST., ... WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah S McClure

6 DATE OF BIRTH (month, day, and year): Jan 24 1855

7 AGE: Years 69 | Months 4 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Manager

(b) General nature of industry, business, or establishment in which employed (or employer): Dentists Laboratory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Columbia Pa.

PARENTS

10 NAME OF FATHER: John A McClure

11 BIRTHPLACE OF FATHER (city or town) (State or country): Columbia Pa

12 MAIDEN NAME OF MOTHER: Mary M Clure

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lancaster Pa

11 Informant (Address): Dr J Sheridan Wilson

15

MAY 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21 - 1924

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to May 21, 1924.

that I last saw him alive on May 20 - 1924.

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Pulmonary Edema -

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No - Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert Sindeland, M. D.

May 23 1924 (Address) 211 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western cemetery	May 25 1924
UNDERTAKER	ADDRESS
F D Klepfer Sons	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87216

CERTIFICATE OF DEATH.

X 31 D 87216

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Hollins ST., 18 WARD)

2-FULL NAME Pearle Buckmaster

(a) RESIDENCE NO. 914 Hollins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
♂	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10/24/15

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Emory A. Buckmaster

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Hall

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Mrs Emory A. Buckmaster.
(Address) 914 Hollins St.

15 MAY 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/ 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/15/24, 19..., to 5/22/24, 19...,

that I last saw her alive on 5/22/24, 19...,

and that death occurred, on the date stated above, at 7 10 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ... yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Bernard H. Tenny M. D.

(Address) 910 West End

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's M E Cem Frederick Md.	May 25 1924
20 UNDERTAKER	ADDRESS
John J. Georgen & Son, Inc. Per F. J. Cowan	901 Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87217

101-001 ✓ D 87217

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer of Amer Hospital 418 W. Lexington St. 19 WARD)

2-FULL NAME Delia Osborn

(a) RESIDENCE. NO. 1630 W. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred More than 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Osborne

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator at factory

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 MAY 23 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17

I HEREBY CERTIFY, That I attended deceased from May 19. 1924 to May 20. 1924.

that I last saw h alive on May 20. 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1630 W. Fayette

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) E. S. Johnson, M. D.

, 19 (Address) 1212 St. Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cemetery DATE OF BURIAL May 23 1924

UNDERTAKER [illegible] ADDRESS 1531 W. Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001 ✓

D. 87218

CERTIFICATE OF DEATH.

101 D 87218

1-PLACE OF DEATH South Balto Gen'l Hosp

CITY OF BALTIMORE: (No. Light St near Wells St Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Fenzel (Fenzel)

(a) RESIDENCE NO. 1617 Cuba St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) (S)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 8-1920

7 AGE Years 3 Months 7 Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dead (Unknown)

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Minnie Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Maurice Fenzel (Address) 1617 Cuba St

15 MAY 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/24

17 I HEREBY CERTIFY, That I attended deceased from 4-7-24 19.. to 5/22/24 19.., that I last saw h.. alive on 5/22/24, 19.., and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows: Septic Endocarditis

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) H. Elliott Jones, M.D.

, 19 (Address) 1629 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery P.O. DATE OF BURIAL May 24 1924

20 UNDERTAKER Wm Cook ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87219 — 179 — D 87219

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital 1122 n Mount st. ST., 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Beck

(a) RESIDENCE NO. 2731 Prospect st., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Deceased

6 DATE OF BIRTH (month, day, and year) April 7, 1855

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER F. Linden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Beck (Address) 2731 Prospect St

15 Filed MAY 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1924

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to May 22, 1924, that I last saw her alive on May 22, 1924, and that death occurred, on the date stated above, at 1 25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) A. Aisenman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/26 1924

20 UNDERTAKER Mccain Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87220

CERTIFICATE OF DEATH.

90 D 87220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3622 Old York Road ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rebecca D. Meeks

(a) RESIDENCE NO. 3622 Old York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George O. Meeks

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	7	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Richard Hardy

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Robinson

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Elizabeth Dorney
(Address) 3622 Old York ROBERT R. KRAUTER

15 MAY 23 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inqiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Valv. Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma (duration) 5 yrs. mos. ds.

(Signed) J. H. Fallen M. D.
(Coroner.)

May 22/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkington Hanford Co. DATE OF BURIAL 5/24 192

20 UNDERTAKER Brosius Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87221

CERTIFICATE OF DEATH.

4-D 87221

1-PLACE OF DEATH

City of BALTIMORE: (No. 922 N. Duncan St., 7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John R. Radcliffe .....

(a) Residence No..... 922 N. Duncan ....St.,.....Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Katie Radcliffe

6-DATE OF BIRTH (month, day and year) June 10 1861

7-AGE, 62 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Piano Mfr.

(b) General nature of industry, business, or establishment in which employed (or employer)..... Owner

(c) Name of employer..... Self

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Samuel Radcliffe

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Sarah Duffy

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country) Baltimore Md

14- (Informant) Carrie E. Sapp

(Address) 2405 E. Biddle St.

15- MAY 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24 24

17- I HEREBY CERTIFY, That I attended deceased from May 16, 19 24, to May 22 19 24, that I last saw him alive on May 24, 19 24 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Fred Murphy M. D.

(Address) 1500 Mott St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Cemetery	May 24 1924
20-UNDERTAKER,	ADDRESS
William Cadwallader	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 87222

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Maree St. ST., 17 WARD)

2-FULL NAME Eliza Thomas

(a) RESIDENCE NO. 2412 Maree St. ST., WARD.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Edgar T. Thomas Deceased

6 DATE OF BIRTH (month, day, and year) May 26 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hunt Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C. Tenn.

14 Informant Gertrude Thomas

(Address) 2412 Maree St.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

MAY 31 1924 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 20, 1924, that I last saw h.. alive on May 20, 1924, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Death Caused per Contusion due to Acute Suppuration Gastritis

(duration) ..... yrs. ..... mos. 1 ½ ds.

CONTRIBUTORY (Secondary) Acute Suppuration Gastritis (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Gertrude Hall, M. D.

, 19 (Address) 1126 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL May 23 1924

20 UNDERTAKER Mrs. R. C. Elliott — ADDRESS 1126 Eastlan Ave

Spec.—1-1021 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87223

CERTIFICATE OF DEATH.

74-001 ✓ D 87223

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brown

(a) RESIDENCE NO. 911 N. Carolina st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Brown

6 DATE OF BIRTH (month, day, and year) 1-20-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Lillie Brown

(Address) 1302 Jeff

15 MAY 2 3 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 20 1924

that I last saw him alive on May 20 1924

and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Chronic hypertension

Arteriosclerosis Cardiac hypertrophy

Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes. Autopsy findings

What test confirmed diagnosis?

(Signed) Wm Fowler Jr., M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL May 24 1924

20 UNDERTAKER Mrs J. H. Locks

ADDRESS 1302 Jeffers

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question on this form should be answered and every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37224

CERTIFICATE OF DEATH.

10 1 0 01 ✓ 37224

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 610 Cornell St. ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Brown

(a) RESIDENCE. No. 616 Cornell St. ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1882 (Estimated)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Corporation

(c) Name of employer Car No 2 Pratt St.

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Hattie Pettway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Mrs [illegible] (Address) 616 Cornell St

15 MAY 23 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20- 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-18- 1924, to 5-20- 1924, that I last saw h.. alive on May 20th 1924, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 610 Connell St

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas A Carson, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Auburn Cemetery	5/22/24
20 UNDERTAKER Jno. G. H. Hoffman	ADDRESS 486 W. Conway St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Time of burial extended to May 26/24

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87225

D 87225

J. Frederick Kemper
85 Asst. Coroner

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Percy Sinclair

(Residence in Baltimore: No. 652 W. Fayette Street St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Mw

6-DATE OF BIRTH, Mu known (Month) (Day) 1859 (Year)

Mu known

65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Eli M. Fishpaw

9-BIRTHPLACE, (State or Country), US.

PARENTS.

10-NAME OF FATHER. Mu known

11-BIRTHPLACE OF FATHER, (State or Country) Mu known

12-MAIDEN NAME OF MOTHER, Mu known

13-BIRTHPLACE OF MOTHER, (State or Country) Mu known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Eli L. M. Fishpaw

(Address) 11 N. Gilmor Street

15- MAY 23 1924 Burial Permit Clerk. Ruth R. KRAUTH,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 15th (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to His death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident

Multiple Fractures

(Duration) 0 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shocks. (mw)

(Duration) 1 yrs. 5 mos. 1 ds.

(Signed) Geo Edwin Radcliff M. D.
(Coroner.)

5-21 1924 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loraine Co. DATE OF BURIAL, May 24 1924

20-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Bells St.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87226

91-002 D 87226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1514 N. Callington ave 8 Registered No.....

City of BALTIMORE: (No. 1514 N. Callington ave St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick F. Connor

(a) Residence No. 1514 N. Callington ave St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced.~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (~~or~~) ~~WIFE of~~ Mary K Connor

6-DATE OF BIRTH (month, day and year) Dec 28 1861

7-AGE. 62 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)..... 039
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Co

PARENTS.

10-NAME OF FATHER, John Connor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Kelleane

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mary K Connor (wife)
(Address) 1514 N Callington ave

15- Robert F. Carrick,
May 23 192.... Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 23 1924 to May 21 1924 that I last saw him alive on May 21 1924 and that death occurred, on the date stated above, at 8.40 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
Enteritis & Cerebrosis

(Duration) yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Cerebral Enteritis & Cerebrosis

To any trouble? (Duration) yrs. 4 mos. ds.

18-Where was disease contracted if not at place of death? Home in bed

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Manual test

(Signed) C. L. Mackenrodt M. D.

May 22, 1924 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 24 1924

20-UNDERTAKER: Robt. F. Turner Son — ADDRESS: 1695 N. Broadway

MAY 23 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very Important.

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87227

CERTIFICATE OF DEATH.

1290 87227

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 728 Light ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bosse Sr.

(a) RESIDENCE NO. 728 Light ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Bosse

6 DATE OF BIRTH (month, day, and year) Feb 26 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Bosse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Bosse Jr. (Address) 728 Light St

15 Date MAY 23 1924 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to May 21, 1924; that I last saw h— alive on May 21, 1924; and that death occurred, on the date stated above, at 5-10 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chr nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. Wilkerson M. D.

19 (Address) 119 S. West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C A Co — DATE OF BURIAL 5-24 1924

20 UNDERTAKER Ex B Hark — ADDRESS 115 E West St

MAY 23 1924

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87228

161-00/D 87228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 Orchard ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Henson

(a) RESIDENCE NO. 437 Orchard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21st 1924

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day 10 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ✓ 000

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Henson

11 BIRTHPLACE OF FATHER (city or town) A.A. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosie Edmonds

13 BIRTHPLACE OF MOTHER (city or town) Louisville (State or country) Ky.

14 Informant (Address)

15 MAY 23 1924 Robert P. Harrison, .19 Registrar

Muriel Perrill Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from May 21st, 1924, to May 22nd, 1924, that I last saw her alive on May 21st, 1924, and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity 28 wks.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Maternal Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clin. & Lab.

(Signed) Louis A. Wolf Lass M. D.

5-22- 1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL

Commissioner Health.

MAY 23 1924

WM. E. WOODALL

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

ec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87229

CERTIFICATE OF DEATH.

74 001 ✓ D 87229

1-PLACE OF DEATH

City of BALTIMORE: (No. 150 N. Fulton ave St., 6 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary L. Buck

(a) Residence No... 150 N. Fulton ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single,~~ ~~Married~~ Widowed, ~~or Divorced.~~ (~~Write the word.~~) Married

5a-If married, widowed, ~~or divorced~~ ~~HUSBAND of (or)~~ WIFE of Wm. Buck

6-DATE OF BIRTH (month, day and year) Jan. 12-1848

7-AGE. 76 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, Jas Starbey

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), City

12-MAIDEN NAME OF MOTHER, Cath. Roberts

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), City

14-

(Informant) Helen Ehrman

(Address)..... 150 N. Fulton ave

15-

Filed ..... 19..... Robert P. Harrison, Registrar.

MAY 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5/22/24

17- I HEREBY CERTIFY, That I attended deceased from May 19, 1924, to May 22, 1924, that I last saw her alive on May 21, 1924, and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 5 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? At Home 7 Buck

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J.G. Emerson M. D.

5/23, 1924 (Address) 2303 N. Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore City — DATE OF BURIAL, May 24 1924

20-UNDERTAKER, J.G. Inman — ADDRESS 3000 E. Baltimore St.

WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St., 76 Ward) X 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary V. Cohen

(a) RESIDENCE No. Woodbine, near Eastern Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua Cohen

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Andrew A. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Amelia A.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Joshua Cohen (Address) 1911 Eastern Ave

15 Filed MAY 23 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to May 22, 1924, that I last saw her alive on May 22, 1924, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis & Uremia

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isidor J. Frey, M. D.

May, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 5/26 1924

20 UNDERTAKER J. C. Moan — ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MEDICATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McQuade

(a) RESIDENCE NO. 1327 Seventeen St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James McQuade

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Boylan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Levi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address)

Filed MAY 23 1924, 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/24

17 I HEREBY CERTIFY, That I attended deceased from 5/16/24, 19.., to 5/21/24, 19.., that I last saw h alive on 5/21/24, 19.., and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of 5/24/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) K. W. Hartley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Cemetery	5/24/ 1924
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Baltimore

(Manner)

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87232 D 87232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 7

CITY OF BALTIMORE: (No. 2108 Bank St., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Catherine Maurer

(a) RESIDENCE NO. 2108 Bank ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5-22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	1	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER John Pius Maurer

11 BIRTHPLACE OF FATHER (city or town) Balto md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Truss

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country)

14 Informant Margaret Truss
(Address)

15 Filed ....., 19 Robert F. Garrison, Registrar

JY 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/14, 1924, to 5/22, 1924, that I last saw h-y alive on 5/14, 1924, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

measles

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) measles

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Daniel O'Brien, M. D.

, 19 (Address) 3525 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	5/24, 1924
20 UNDERTAKER John A. Morad	ADDRESS 5806 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87233

CERTIFICATE OF DEATH.

D 87233

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1120 N. Fulton Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Shannon

(a) Residence No. 1120 N. Fulton Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ::::::::

6-DATE OF BIRTH (month, day and year) July, 17-1917

7-AGE.			If LESS than 1 day.
6 yrs.	10 mos.	5 ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)

(State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER John J. Shannon

11-BIRTHPLACE OF FATHER (city or town)

(State or Country) Ireland

12-MAIDEN NAME OF MOTHER Mary E. Shanahan

13-BIRTHPLACE OF MOTHER (city or town)

(State or Country) Balto. Md.

14- (Informant) Mr. John J. Shannon

(Address) 1120 N. Fulton Ave.

15- Filed ... Robert P. Harris Registrar.

MAY 2 31924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22—1924

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to May 22 1924

that I last saw her alive on May 22 1924

and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Scarlet Fever (Cured)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Gilchrist M. D

, 19 (Address) 711 N. Lanvale St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	May 26—1924
20-UNDERTAKER.	ADDRESS
Chas. F. Evans & Son Inc.	118 W. Mt Royal Ave

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87234

CERTIFICATE OF DEATH.

148 D 87234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 7 WARD)

2-FULL NAME Genevine M Umphreyes

(a) RESIDENCE No. 5 Belvedre Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm D Umphreyes

6 DATE OF BIRTH (month, day, and year) Jan 12 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Steven Scales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Conley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm D Umphreyes (Address) 5 Belvedere Ave

15 Filed ..., 19.. Robert F. Garrison, Registrar

Burial Permit Given

AY 2 31924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 23, 1924, that I last saw her alive on May 23, 1924 and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Eclampsia of Pregnancy.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 23-24

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J V Jazlovich, M. D.

5-23 1924 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL May 26 1924

20 UNDERTAKER Chesmuth & Dar ADDRESS 25 Eutaw Cm

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87235

HEALTH DEPARTMENT—CITY OF BALTIMORE

1610 D 87235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3637 Chestnut Ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Thomas Slaughter

(a) Residence No. 3637 Chestnut Ave St., 13 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 23/24

7-AGE,	If LESS than 1 day,
1 yrs. 0 mos. 2 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Ernest B. Slaughter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Lillie Munson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Ernest B. Slaughter

(Address) 3637 Chestnut Ave

15- Filed MAY 25 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 23/24

17- I HEREBY CERTIFY, That I attended deceased from May 21, 19 24, to May 23, 19 24, that I last saw h. alive on May 22, 19 24, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Compound Fracture

Base of Skull Fracture

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Apparent Symptoms

(Signed) C. B. Farrell, M. D.

, 19 (Address) 3637 Chestnut Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St. Marys Hum[illegible]	May 24 1924
20-UNDERTAKER	ADDRESS
CHENOWETH & SON	3637 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17161 81

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 87236

87236

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. JOHNS HOPKINS HOSPITAL ST., 13 WARD)

2-FULL NAME Herbert George

(a) RESIDENCE NO. 701 Crisp St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 28, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
—	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schedule fitter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Godley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed MAY 23 1924, 19.... Robert F. Griffith Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1924 to May 23, 1924, that I last saw h~~e~~ alive on May 23, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Indigestion

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Acute Cervical adenitis

(duration) ..... yrs. ..... mos. 27 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/25/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R Bagg, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 24, 1924
20 UNDERTAKER	ADDRESS
Ebenezer Lee	367 Cheapside

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1769 D 87237

CERTIFICATE OF DEATH.

24 D 87237

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Myrtle Vaeth

(a) RESIDENCE NO. 313 N. Carolina St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) Mar 7 1919

7 AGE — Years: 5 — Months: 3 — Days: 16 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Vaeth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Emma Walz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Resdo.

(Address) JOHNS HOPKINS HOSPITAL

15 (Filed) MAY 23 1924 Robert F. Garrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 23, 1924,

that I last saw h.. alive on May 23, 1924

and that death occurred, on the date stated above, at 3 45 p. m.

The CAUSE OF DEATH* was as follows:

Epidemic Meningitis (Meningococcus)

(duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/22/24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Burg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 5/24 1924

20 UNDERTAKER: Philip Henrig

ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D 87238

87238

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St., 24 WARD)

2-FULL NAME Julius Eickert

(a) RESIDENCE NO. 1730 Hull St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. [redacted] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Christine Eickert

6 DATE OF BIRTH (month, day, and year) Feb. 15-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper 034

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Eickert

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christine Eickert
(Address) 1730 Hull St

15 MAY 23 1924 Robert E. Harris M.D., Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20 1924, to May 21 1924, that I last saw h[redacted] alive on May 21 1924, and that death occurred, on the date stated above, at 6:55P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis
Intestinal Obstruction

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 21 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) K.C. Rice, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 5/24/24

20 UNDERTAKER George Leimbach & Son — ADDESS 647 W Pratt

A.Y. 2

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155D 87239

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3001 Philadelphia ave. WARD 6)

2-FULL NAME Luella Corasaniti

(a) RESIDENCE NO. 3001 Philadelphia ave. WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 12 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Frank Corasaniti

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Anna Cappis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Frank Corasaniti
(Address) 3001 Philadelphia

15 MAY 24 1924 Robert P. Garrison, Registrar

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 4-28-1924, to 5-23-24, 19....,

that I last saw her alive on 5-23-24, 19....,

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Acute Mastoiditis

(duration) ..... yrs. ..... mos 1.4 ds.

CONTRIBUTORY (Secondary) Septico-pyemia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) + J. J. Dressman M. D.

5-24-24 (Address) 1919 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 25 1924

20 UNDERTAKER Wendell Dippel & Son

ADDRESS 378 Ann

Spec.—1-10-21—M&T—1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87240

CERTIFICATE OF DEATH.

D 87240

1-PLACE OF DEATH

CITY OF BALTIMORE) (No. 2803 Brehm Ct. ST., 9 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Ann Hewell

(a) RESIDENCE NO. 2803 Brehm Ct. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John R. Hewell

6 DATE OF BIRTH (month, day and year): November 6th 1859

7 AGE — Years: 64 — Months: 6 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Samuel Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Martha A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Lewis T. Hewell

(Address): 2803 Brehm Ct.

MAY 24 1924 Robert F. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 23rd 1924 to May 22nd 1924

that I last saw him alive on May 22nd 1924

and that death occurred, on the date stated above, at 11.25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Exam

(Signed) Geo. W. Armstrong M.D.

(Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: May 26 1924

20 UNDERTAKER: W. H. Cook

ADDRESS: 582 E. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87241

CERTIFICATE OF DEATH.

48 D 87241

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Dorsey

(a) RESIDENCE NO. 8 S. Gilmor ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lola Dorsey

6 DATE OF BIRTH (month, day, and year): Oct 27 1847

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: City Fire Dept

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records

(Address)

15 MAY 24 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/23/24

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1924, to 5/23/1924,

that I last saw h alive on 5/23/24, 19,

and that death occurred, on the date stated above, at 10:05 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Face

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): X-ray burns.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Hedley, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 26 1924

20 UNDERTAKER: John Leavitt & Co — ADDRESS: 50 E. Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 345 So. 14th St., No Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Natale Fortuna

(a) Residence No. 345 So. 14th St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 10/30-23

7-AGE. ..... yrs. 6 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town). (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, Natale Fortuna

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Olimpia Fiorini

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Italy

11- (Informant) Natale Fortuna

(Address) 345 So 14th St

15- Filed ..... 192 Robert P. Harrison, Registrar.

MAY 24 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 23/24

17- I HEREBY CERTIFY, That I attended deceased from May 20/ 1924 to May 23/ 1924

that I last saw h.. alive on May 23 1924

and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... yrs. ..... mos. 3 ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) P. Artigiani M. D.

. 19 (Address) 2942 Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Vincents Cem — DATE OF BURIAL. 5/24 1924

20-UNDERTAKER George J Ruth — ADDRESS 1735 Harford Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87243

D 87243

100001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1074 Raborg ST., 18 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Boston Jr

(a) RESIDENCE No. 1074 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 29th 23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	8	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James Boston

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lizzie Dixon

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant James Boston
(Address) 1074 Raborg St

15 Filed MAY 24 1924 Robert P. Garrison
Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Thos B. Norton, M. D.
(Coroner.)
May 23rd 1924 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 24th 192

20 UNDERTAKER	ADDRESS
R. Jones	1115 Gilmor St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87244

CERTIFICATE OF DEATH.

129 D 87244

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1836 W. Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F. Roberts

(a) Residence No. 1836 W. Lanvale St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Estelle Lindsay

6-DATE OF BIRTH (month, day and year) Feby 11 1853.

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

066

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS:

10-NAME OF FATHER Matthias Roberts

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER Cornelia Frey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland.

14- (Informant) Annie E. Roberts

(Address) 1836 W. Lanvale St

15-

Filed Robert P. Garrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 3. 1924. to May 22. 1924.

that I last saw him alive on 22 May 1924.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lethal Fever, following dilatation of Deaf urethra

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Feb 13/24

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Charles Lee, M. D.

May 25, 1924 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Green Mount Cem.	May 24 1924
20-UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 24 1924 Burial Permit Clerk

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87245

D 87245

CERTIFICATE OF DEATH.

172

1-PLACE OF DEATH
CITY OF BALTIMORE, No. Jane A.R. Main Stokes ST., 12 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alonzo. O. Stidham

(a) RESIDENCE No 2617 Hampden WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 25 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Plumer
(b) General nature of industry, business, or establishment in which employed (or employer): 059
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): M D

PARENTS

10 NAME OF FATHER: James Stidham
11 BIRTHPLACE OF FATHER (city or town) (State or country): M D
12 MAIDEN NAME OF MOTHER: Eleanora Millard
13 BIRTHPLACE OF MOTHER (city or town) (State or country): M D

14 Informant: James H. Stidham
(Address) 2617 Hampden ave

15 Filed MAY 24 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry. find that said deceased came to his death on the day stated above. Mulch Fowler
The CAUSE OF DEATH was as follows:

Suicide
Jump from Bridge
(duration) yrs. mos 1 ds.
CONTRIBUTORY (Secondary) Shock.
(duration) yrs. mos. ds.

(Signed) Geo Clinton Keidel, M. D.
(Coroner.)
May 23 192 (Address) 1143 to Bm

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	May 24 1924
UNDERTAKER: Greenawelt & Son	ADDRESS: 36 Chestnut ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87246

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Russell

(a) RESIDENCE NO. 1812 Warwick ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward A. Russell

6 DATE OF BIRTH (month, day, and year) Oct 20-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Houswife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Susan Finley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edward A. Russell

(Address) 1812 Warwick ave

15 Filed MAY 24 1924 Robert P. Harrison, Registrar

Burial Permit Card.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1924 to May 23, 1924.

that I last saw her alive on May 23, 1924,

and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

Terminal Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Possible carcinoma liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1812 Warwick Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo B. Lybert, M. D.

, 19 (Address) St Josphs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral May	26 1924
20 UNDERTAKER	ADDRESS
H. C. Wiedefeld	914 Gunnit Ave

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87247

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Downs

(a) Residence No. 910 Wilmore Alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6-DATE OF BIRTH (month, day and year): 1861

7-AGE.			If LESS than 1 day,
63 yrs.	mos.	ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: William Downs

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Mary Chew

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14-Informant: Hospital Records

(Address): M.T.H.

15-Filed MAY 24 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 23, 1924, that I last saw him alive on May 23, 1924, and that death occurred, on the date stated above, at 6.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Labb, M. D

5-23-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 5-26-24
Woodlawn Cem	
20-UNDERTAKER, David Garson	ADDRESS 916 Baron

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87248

CERTIFICATE OF DEATH.

90 D 87248

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Municipal Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Gassoway

(a) RESIDENCE. No. 1423 Argyle ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John Gassoway

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed MAY 24 1924 19

Robert P. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1924 to 5-22, 1924

that I last saw him alive on 5-21, 1924

and that death occurred, on the date stated above, at 12-30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Chronic myocarditis; auricular fibrillation; myocardial decompensation (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude S. Drake M. D.

5-22 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnsville Cem	5-25 1924
20 UNDERTAKER David Easton	ADDRESS 916 Pa Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 37249

CERTIFICATE OF DEATH.

D 37249

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 Fawn St., 17 Ward) 31

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Emma L. Walker

(a) Residence No.... 608 Fawn St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col

5-State, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. Walker

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 37 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)..... — 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Unknown

(State or Country),

PARENTS.

10-NAME OF FATHER, Jas. Justis

11-BIRTHPLACE OF FATHER (city or town)..... Va.

(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Scott

13-BIRTHPLACE OF MOTHER (city or town)..... Md.

(State or Country),

14- (Informant) Family Records

(Address) 608 Fawn St

15- Filed ..... 192.

Robert P. Harrison,

Registrar.

MAY 24 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 23

17- I HEREBY CERTIFY, That I attended deceased from January 18, 1924, to May 23 1924, that I last saw her alive on May 22, 1924 and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) Brandenburg M. D.

5/24/, 1924 (Address) 1006 Edmonson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Laurel Cem

DATE OF BURIAL, 5-26, 1924

20-UNDERTAKER, Daniel Easton

ADDRESS 766 Carey

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87250 D 87250

CERTIFICATE OF DEATH. X 23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) Md. Gen'l Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Eichelberger

(a) RESIDENCE NO. Union Bridge Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	Single, Married, Widowed, or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 1-22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Zion Md

PARENTS

10 NAME OF FATHER C. E. Eichberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll

14 Informant Jane Eichelberger

(Address) Union Bridge Md

15 Filed MAY 24 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24 1924

17 I HEREBY CERTIFY, That I attended deceased from M.V. 23, 19..., to 5-24, 1924,

that I last saw h/M alive on 5-24, 1924,

and that death occurred, on the date stated above, at 1 40 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. 5 mos 24 ds.

CONTRIBUTORY (Secondary) Toxemia - cardiac failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 4-15-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Jno A Jamison King, M. D.

, 19 (Address) Md Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL A M Rouzer

DATE OF BURIAL May 26 1924

20 UNDERTAKER Unionbridge Md.

ADDRESS 223 S N Mott

Spec.—1-10-21—M&T—1500 Bks.

D 87251

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87251

CERTIFICATE OF DEATH.

REGISTERED NO. 91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 S. Lakewood ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta W. Kruamann.

(a) RESIDENCE No. 603 S. Lakewood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Kruamann

6 DATE OF BIRTH (month, day, and year) Dec. 10-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Geo. F. Sapp.

(Address) 603 S. Lakewood Ave

15 MAY 24 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1924, to May 23, 1924, that I last saw her alive on May 23, 1924, and that death occurred, on the date stated above, at 3.35 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bronchitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. L. Burke M. D.

May 23 1924 (Address) 3042 Frederick Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL May 25 19 24

20 UNDERTAKER Fickler & Fickler

ADDRESS Eager

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87252

CERTIFICATE OF DEATH.

90 D 87252

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 N. Chester ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry M. Taylor

(a) RESIDENCE NO. 622 N. Chester ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Taylor

6 DATE OF BIRTH (month, day, and year): June 12, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant, Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ellice Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Catherine Taylor

(Address) 622 N. Chester St

15 Robert P. Harrison, Registrar

MAY 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr 28, 1924, to May 22, 1924,

that I last saw him alive on May 22, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary): Barber Comp.

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — What test confirmed diagnosis? Phy Ex

(Signed) Geo Clinton Bladd M. D.

May 23, 1924 (Address) 1437 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 26 1924
20 UNDERTAKER: Kirkler & Kirkler	ADDRESS: 1739 Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12013 B 87253 — B 87253 — 29 B 87253

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 70 (WARD)

2-FULL NAME Ethel Gerstenhauer

(a) RESIDENCE No. 3055 E. Fredrick (3055 E. Stafford St.) ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 30, 1921

7 AGE: Years 2 | Months 11 | Days 23. | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Hugo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Ambach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mother (Address) JOHNS HOPKINS HOSPITAL.

15 Filed MAY 24 1924, 19 ..... Robert P. Harrison, Registrar

Burial Permit Gert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 19 24

17 I HEREBY CERTIFY, That I attended deceased from May 16, 19 24, to May 23, 19 24

that I last saw her alive on May 23, 19 24

and that death occurred, on the date stated above, at 7 40 a.m.

The CAUSE OF DEATH* was as follows:

Tetanus

(Over)

(duration) ..... yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Bugg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 26, 1924

20 UNDERTAKER: C. W. Dill — ADDRESS: 309 Fredk. Ave.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87254

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3259 Chestnut Ave ST., 13 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna M. Carr

(a) RESIDENCE No. 3259 Chestnut Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 29-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Washington Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER John H. Carr

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Martha A. Hines

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs. Laura B. Grim
(Address) 3259 Chestnut Ave

15 MAY 24 1924 Robert P. Garrison,
Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison M. D.
(Coroner.)

May 23 1924 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 24 1924

20 UNDERTAKER Horace H. Burger — ADDRESS 3631 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87255

D 87255

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. St. Agnes Hosp. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Martin

(a) Residence No. 1427 N. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.)
Male	W. White	

5a-If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of

6-DATE OF BIRTH (month, day and year) [illegible] 1891

7-AGE.	If LESS than 1 day,
33 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9-BIRTHPLACE (city or town) Balt. Md.
(State or Country).

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country).

12-MAIDEN NAME OF MOTHER, Unknown.

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Md.

11- (Informant) Mrs Morgarella Morton

(Address) 1427 N Lombard St.

15-

Filed 192

Robert P. Harrison, Registrar.

MAY 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22 1924

17- I HEREBY CERTIFY, That I attended deceased from

5/16 19 24, to 5/22 19 24

that I last saw h. ~~im~~ alive on 5/22 19 24,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Dudley P. Bowie M. D

19 (Address) 904 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	May 26, 1924
20-UNDERTAKER.	ADDRESS
John F. Gorman & Co.	701 Hollins St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87256

D 87256

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Ramsay ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola C. Cooke.

(a) RESIDENCE NO. 905 Ramsay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Cooke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lillian M. Wilkens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr John Cooke
(Address) 905 Ramsay St

15 Filed MAY 24 1924, 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/22/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/22/24 19 ..., to 5/22/24 19 ...,
that I last saw h— alive on 5/22/24, 19
and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Histoplasmosis

Peritonitis 2

(duration) yrs. mos 2 wks 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Seng, M. D.

19 24 (Address) 410 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery

DATE OF BURIAL May 24 1924

20 UNDERTAKER John F. Cowan Est, Per F. J. Cowan

ADDRESS 901 Hollins

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87257

CERTIFICATE OF DEATH.

1729 D 87257

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 823 N Carolina St. ; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Ludloff.

(Residence in Baltimore: No. 823 N Carolina St. St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, January 17, 1856 (Month) (Day) (Year)

7-AGE. 68 yrs. 4 mos. 9 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Salesman 66
(b) General nature of industry, business, or establishment in which employed (or employer)..... Insurance

9-BIRTHPLACE, (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jacob Ludloff.

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Henry E. Ludloff

(Address) 1642 E. 25th St.

15-

Filed ....., 191.. Robert P. Garrison, Registrar. Burial Permit Clerk.

MAY 24 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 21, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 19 1924 to May 21 1924, that I saw him alive on May 21 1924, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis and arterial hypertension

(Duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Influenza

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Allan Ousler M.D.

May 22, 1924 (Address) 3627 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, May 24, 1924

20-UNDERTAKER Harry A. Wolfe ADDRESS 1531 W. Lombard St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87258

CERTIFICATE OF DEATH.

17180 D 87258 ✓ * 24

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.....

2-FULL NAME James A Grove

(a) RESIDENCE NO. 135 Conduit St WARD Annapolis Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Dec 26 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Grove

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary one Steffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed MAY 24 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to May 23, 1924, that I last saw him alive on May 23, 1924, and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, Acute Epidemic (see other side)

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Acute Gastro-intestinal Indigest

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy & Bacteria from Spinal fluid

(Signed) Casper Fales M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Naval Cemetery Annapolis Md

DATE OF BURIAL May 24 1924

20 UNDERTAKER B L Hopkins

ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... mation should be stated EXACTLY. Exact statement of OCCUPATION ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87259 — 87259

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 W. Biddle St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Georgianna Brown

(a) RESIDENCE NO. 417 W. Biddle St., WARD Staunton Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec? 1880

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	5	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Maliza Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Virginia Brown (Address) 417 W. Biddle St.

15 Filed MAY 24 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

May 23, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 27 1924
20 UNDERTAKER Saml D Hemsley	ADDRESS 527 N Gilmor St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87260

CERTIFICATE OF DEATH.

90 D 87260

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N. Lanvale ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Johnson

(a) RESIDENCE. No. 611 N. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Johnson

6 DATE OF BIRTH (month, day, and year): Apr 17 1880

7 AGE — Years: 44 Months: 1 Days: 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant (Address): John W. Johnson 611 N. Lanvale St.

15 Filed May 24 . 19 24 Robert P. Garrison, Registrar

MAY 24 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23rd 1924

17 I HEREBY CERTIFY, That I attended deceased from July 15 . 1923 , to May 22nd . 19 24

that I last saw h alive on May 22 . 19 24

and that death occurred, on the date stated above, at 5.05 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. H. Lautenbach M. D.

May 23 . 19 24 (Address) 2215 N. Monroe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 26 24
20 UNDERTAKER: Samuel J. Hensley	ADDRESS 778 N Bond

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Mack)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87261

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2133 Druid Hill Ave.

CITY OF BALTIMORE: (No. 2133 Dru. Ave. ST., 14 WARD)

2-FULL NAME Elza H. Mack

(a) RESIDENCE No. 2133 Dru. Ave. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

1-001
D 87261

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel J. Mack

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Richard Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Montague

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Daniel J. Mack
(Address) 2133 Dru. Ave.

15 MAY 24 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20 1924, to May 21st 1924, that I last saw h[e] alive on May 21st 1924, and that death occurred, on the date stated above, at 10:05 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Nephritis

(duration) yrs. mos. 2 Dys.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

19 (Address) 92 4 West

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL May 25 1924

20 UNDERTAKER Samuel D. Hensley ADDRESS 1 N. Bradford

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87262

CERTIFICATE OF DEATH.

13D 87262

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Dukeland West. 16 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Vernon Bopp

(a) RESIDENCE. No. 602 Dukeland West. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 13-1923

7 AGE — Years: 1 — Months: 0 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: August G. Bopp

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Carrie E. Marrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): August G. Bopp 602 Dukeland Ave.

15 Filed ... 19 ... Robert P. Harrison, Registrar

Burial Permit Cert.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to May 23, 1924, that I last saw him alive on May 23, 1924, and that death occurred, on the date stated above, at 2-10 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions terminating
Enteric Colitis

(duration) ✓ yrs. ✓ mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ✓ yrs. ✓ mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D.

May 28 1924 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 5-26-1924

20 UNDERTAKER: E & B Hasle — ADDRESS: 1158 West St

MAY 27 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87263

CERTIFICATE OF DEATH.

90 D 87263

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2323 Eager Place St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Doetsch.

(a) Residence No. 2323 Eager Place St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John. Doetsch.

6-DATE OF BIRTH (month, day and year) Dec 30-1857

7-AGE. 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), not known

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). not known

14- (Informant) John. Doetsch.

(Address) 2323. Eager Place

15- Filed MAY 2 1924 Robert F. Harrison, Registrar.

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 22nd 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 19 24 to May 22 19 24

that I last saw h[illegible] alive on May 21 19 24

and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Lethal Puerperal tetanus

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5-23 19 24 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bait. Cem. DATE OF BURIAL. 5-26th 19 24

20-UNDERTAKER. Mrs Chas A Rohde ADDRESS 1200 Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.—400 Bks.

(Smith)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87264 ✓

D 87264

CERTIFICATE OF DEATH.

17

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Franklin Square Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. J. Cephas Smith

(a) Residence No. 1610 Barclay St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (~~Write the~~ word) single

5a-If ~~married, widowed, or divorced~~ ~~HUSBAND of (or) WIFE of~~ single

6-DATE OF BIRTH (month, day and year) Nov 9 1895

7-AGE. 28 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). Post office

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS:

10-NAME OF FATHER. Jacob Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Florida Shuckles

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Florida Smith

(Address) 1610 Barclay St.

15- Filed MAY 24 1924 192 Robert P. Garrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 23, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 17 1924 to May 23 1924

that I last saw h. alive on May 23 1924

and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Thrombosis Coronary

Pericarditis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Septic infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 17, 24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Dorsey M. D

May 24 1924 (Address) 132 E Caroline

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet

DATE OF BURIAL. May 26, 1924

20-UNDERTAKER. Wm Leavell

ADDRESS 501 E Monument

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Kunkel) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87265

D 87265

CERTIFICATE OF DEATH.

23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Martha Kunkle

(a) RESIDENCE NO. Mt Hope Retreat ST. 28th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 16 ds. How long in U. S., If of foreign birth? [illegible] yrs. [illegible] mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Kunkle

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	28	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife of Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer —

9 BIRTHPLACE (city or town) Duffel (State or country) Belgium

PARENTS

10 NAME OF FATHER Embaltus Van Gestel

11 BIRTHPLACE OF FATHER (city or town) Tilburg (State or country) Holland

12 MAIDEN NAME OF MOTHER Rosalie Lukens

13 BIRTHPLACE OF MOTHER (city or town) Duffel (State or country) Belgium

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat

15 Robert P. Harrison, .19 ..... Registrar

MAY 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6 , 1924 , to May 22nd , 1924 , that I last saw her alive on May 21st , 1924 , and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

abt (duration) 0 yrs. 9 mos 0 ds.

CONTRIBUTORY (Secondary) Mania Hysterica

abt (duration) 0 yrs. 9 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 22nd 1924 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL May 26 1924

20 UNDERTAKER J. K. Talley Wood

ADDRESS 518 Light St.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87266

74-B 87266

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. James F. Cassidy

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1850

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Laborer 040
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (city or town) (State or Country). [illegible]

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). [illegible]

14- (Informant) Municipal Hospital Records
(Address).....

15- Received MAY 24 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-8-24

17- I HEREBY CERTIFY, That I attended deceased from 4-29, 1924, to 5-8, 1924,
that I last saw h~~im~~ alive on 5-8, 1924,
and that death occurred, on the date stated above, at 6.20 P.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Right Hemiplegia)
(Duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death? No Date of.....
Was there an autopsy? No
What test confirmed diagnosis? Sub.
(Signed) Claude S. Dorsey M. D
5-8, 1924 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 5/24, 1924
Laurel Dust.	
20-UNDERTAKER. J. Edw. Sons	ADDRESS 318 Light St.

1—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87267

CERTIFICATE OF DEATH.

47 D 87267

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 S Chester ST.: V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Kowalski

(a) RESIDENCE. No. 12 S Chester ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Packer
(b) General nature of industry, business, or establishment in which employed (or employer) Libbs
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Kowalski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Lechert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Kowalski
(Address) 12 S Chester

15 Robert P. Harrison. Registrar

MAY 24 1924

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1921 to May 23 1924
that I last saw h.r alive on May 24 1924
and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma
Breast
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 1921

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) Francis J Kelly, M. D.

5/23 1924 (Address) 1108 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosaries	May 27 1924
20 UNDERTAKER	ADDRESS
Wendell Dysel & Son	378 [illegible]

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] may be made. See instructions on back of certificates. ATION is very important.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

171 318 D 87268

CERTIFICATE OF DEATH.

X 131 D 87268

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME George A. Myers

(a) RESIDENCE NO. Lineboro, Penna WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
78	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Mathew Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Nancy Stevenhall

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 MAY 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1924

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1924, to May 24, 1924

that I last saw h—alive on May 24, 1924

and that death occurred, on the date stated above, at 11:00 A—m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Pyelonephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Eugene C. Shaw, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lineboro, Pa.	5/27 1924
20 UNDERTAKER Robt. G. Turner & Co	ADDRESS 1412 E. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87269

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 N. Montford ST.: 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Tuma

(a) RESIDENCE. NO. 839 N Montford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Tuma

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Tuma

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mary Tuma

(Address) 839 N Montford

15 Filed MAY 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924 to May 23, 1924, that I last saw h[illegible] alive on May 23, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis following Cellulitis of Left Leg.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cellulitis of Left Leg.

(duration) yrs. 1 mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. D. Rymer, M. D.

May 24-24 (Address) 501 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 26 1924
20 UNDERTAKER	ADDRESS
Frank Snowden	1906 Edmondson

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87270

CERTIFICATE OF DEATH.

D 87270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2326 E. Biddle ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Bornhorn

(a) RESIDENCE NO. 931 Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Elizabeth Bornhorn

6 DATE OF BIRTH (month, day, and year) Dec 29, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
68	68	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

017

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Bornhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Dietel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Josephine Hench
(Address) 2910 Huntingdon Ave

15 MAY 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 23, 1924.

that I last saw h. alive on May 23, 1924

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent V. Foaka, M. D.

, 19 (Address) 845 W. Patt. Pl. Cen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	May 26 1924
20 UNDERTAKER	ADDRESS
Frank E. Fradkin	1066 Cathedral

Spec– 12-23-21– E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87271

CERTIFICATE OF DEATH.

10

D 87271

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2427 Lakeview ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zelda Toffe

(a) Residence No. 2427 Lakeview ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 1921

7-AGE. 3 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Abraham Toffe

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimd

12-MAIDEN NAME OF MOTHER, Anna Silberstein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimd

11- (Informant) Jack Lewis

(Address) 1434 E. Baltd St

13- MAY 25 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 24 24

17- I HEREBY CERTIFY, That I attended deceased from May 19 1924 to May 24 1924, that I last saw h.r alive on May 24 1924 and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(Duration) yrs. mos. 10/12 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) yrs. mos. 4 hrs. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams M. D

May 24, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Hebrew Friendship Cem

DATE OF BURIAL. 5/27 1924

20-UNDERTAKER. Jack Lewis

ADDRESS 1434 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87272

CERTIFICATE OF DEATH.

74-001 V

D 87272

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 516 Harwood Ave ST.; Govans WARD) 37

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nelson Cardwell

(Residence in Baltimore: No. 516 Harwood Ave ST.; Govans 5 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Feb (Month) 21st (Day), 1845 (Year)

7-AGE, 79 yrs. 3 mos. 21 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Nelson Cardwell

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Jane Cardwell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Stevenson

(Address) 516 Harwood Ave

15- Filed MAY 25 1924, 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 23 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 23 1924, that I saw h.m alive on May 23 1924, and that death occurred, on the date stated above, at 3.15 p.m.

The CAUSE OF DEATH* was as follows:

a Cerebral hemorrhage

b. Hemiplegia

(Duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) Geo T Hoskins M. D.

....., 191... (Address) 5835 Gottlieb

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Presbyterian Cemetery Govans

DATE OF BURIAL, May 25, 1924

20-UNDERTAKER Fred'k Lassahn Sons

ADDRESS Fulberton

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87273

CERTIFICATE OF DEATH.

74-001 ✓

D 87273

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles E.Hilseberg ST., 7 WARD)

2-FULL NAME Johns Hopkins Hospital

(a) RESIDENCE NO. 2602 Jefferson St ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Agnes Hilseberg

6 DATE OF BIRTH (month, day, and year) Feb 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Consol. Gas & Electric

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John H. Hilseberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Henrietta Tohl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John E. Hilseberg
(Address) 2012 Robb St

15 Filed MAY 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-(hemorrhage probably)

(duration) .....yrs. most 4 hrs. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) .....yrs. .....mos. .....ds.

(Signed) J. E. Collins, M. D.
(Coroner.)

May 24/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .....yrs., ...mos., ...ds. In the State .....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	May 26 1924
20 UNDERTAKER	ADDRESS
Thos Christian Miller	233 N Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87274 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87274

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 N Bntford ave 6 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Bozze

(a) Residence No. 414 N Bntford ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Bozze

6-DATE OF BIRTH (month, day and year) Nov 10-1839

7-AGE, 85 yrs. 6 mos. 12 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Fleckenstein

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Fleckenstein

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14- (Informant) Elizabeth Culbertson

(Address) 414 N. Bentford Ave

15- Filed MAY 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 22/24

17- I HEREBY CERTIFY, That I attended deceased from June, 1923, to May 22, 1924, that I last saw h.er alive on May 22, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

May 25 1924 (Address) 2008 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer Cem	May 26, 1924
20-UNDERTAKER.	ADDRESS
Chas C. Miller	2334 Jefferson St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 89

D 87275

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1814 Poplar Grove St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Norris Meisel

(a) Residence No. 1814 Poplar Grove St St., Ward

(Usual place of abode) life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: W.

5-~~Single~~, Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine B. Meisel

6-DATE OF BIRTH (month, day and year) April 3rd, 1877

7-AGE: 47 yrs. 1 mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Compositer

(b) General nature of industry, business, or establishment in which employed (or employer): News Paper

(c) Name of employer: American & News

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Louis J. Meisel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Sarah J. Adams

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Penna.

14- (Informant): Mrs. Katherine B. Meisel

(Address): 1814 Poplar Grove St

15- MAY 25 1924 ROBERT R. KRAUTER, Asst. Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 23rd. 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 ....., 19 19 ....., that I last saw h.. alive on May 23 ..... 19 24 and that death occurred, on the date stated above, at 4.00 ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 26 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Jack Frankel M. D.

5/24, 1924 (Address) 2764 N. Charles

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: May 26th, 1924

20-UNDERTAKER: J. Bertram Cole

ADDRESS: 1923 N. Eutaw Street

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87276 ✓ 90 D 87276

CERTIFICATE OF DEATH.

D 87276
1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3001 Parkside Drive St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Margaret Seible Knight

(a) Residence No. 3001 Parkside Drive St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W

5-~~Single~~ Married, ~~Widowed or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Knight

6-DATE OF BIRTH (month, day and year) Nov 18th, 1853

7-AGE. 70 yrs. 6 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baden (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Yost Seible

11-BIRTHPLACE OF FATHER (city or town) Baden (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine -------

13-BIRTHPLACE OF MOTHER (city or town) Baden (State or Country), Germany

14- (Informant) Mrs H. L. Craumer
(Address) 1814 E. Monroe St

15- Filed MAY 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 23rd, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 21 1924 to May 23 1924 that I last saw h.. alive on May 23 1924 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) — yrs. — mos. one ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) one yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Stellman F. Steeman M. D.

, 19 (Address) 6 E Biddle St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Prospect Hill Cem't (Towson	May 26th, 1924
20-UNDERTAKER,	ADDRESS,
Peter M. Hoke	1723 N. Calvert St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87277.

CERTIFICATE OF DEATH.

90

D 87277.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1215 Ashland Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer L. Heath

(a) Residence No. 1215 Ashland Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If ~~married~~, Widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Frances P. Heath

6-DATE OF BIRTH (month, day and year) Oct. 28 1884

7-AGE: 39 yrs. 6 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Foreman

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Tyner Ann C. Md.

PARENTS.

10-NAME OF FATHER: Robert O. Heath.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mollie L. Merrick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Mrs. Frances P. Heath.

(Address) 1215 Ashland Ave

15- MAY 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to May 23 1924

that I last saw h~~im~~ alive on May 23 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ~~No~~ Date of

Was there an autopsy? ~~No~~

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

5-24 1924 (Address) 120 Light St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 27 1924
20-UNDERTAKER	**ADDRESS**
Henry Hauck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87278

CERTIFICATE OF DEATH.

129 ✓ D 87278

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hospital ST., 7 WARD)

2-FULL NAME Hannah Siegelman

(a) RESIDENCE NO. 3120 E. Monument ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. — mos. — ds. How long in U. S., if of foreign birth? 51 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	Widow.

5a If married, widowed, or divorced
~~HUSBAND~~ of ~~his~~ Deb.
(or) WIFE of Henry J. Siegelman

6 DATE OF BIRTH (month, day, and year) March 28 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Romanus Enders

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mr. Siegelman

(Address) 3120 E Monument St

MAY 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 23, 1924, that I last saw h.e alive on May 23, 1924, and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows: Myocardial Insuff.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Harold E. Gillespy M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 27 1924

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87279

CERTIFICATE OF DEATH.

117 D 87279

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. S. 8 WARD)

2-FULL NAME Mrs Florence Meisel

(a) RESIDENCE NO. 2315 E. Lafayette St WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Meisel

6 DATE OF BIRTH (month, day, and year) Sep 6 1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Beris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rose Klaire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gumany

14 Informant George F Meisel (Address) 2315 Lafayette Ave

15 Filed MAY 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 25, 1924, that I last saw her alive on May 25, 1924, and that death occurred, on the date stated above, at 12:20 a m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Gangrenous Appendix

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/24/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A C Mannuger, M. D.

5/24, 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 28, 24
20 UNDERTAKER	ADDRESS
Henry Hovecke & Son	1301 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87280

CERTIFICATE OF DEATH.

179 D 87280

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1411 Decatur St., 24 Ward)

2-FULL NAME John Stoner Warner (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1411 Decatur St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed or divorced, HUSBAND of (or WIFE of) Mary J. Stoner Warner

6-DATE OF BIRTH (month, day and year) 3/10/90

7-AGE 34 yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) 89
(c) Name of employer

9-BIRTHPLACE (City or town) Easton Md.
(State or Country)

PARENTS.
10-NAME OF FATHER John Warner
11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country)
12-MAIDEN NAME OF MOTHER Mad. Fox
13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country)

14- Mary Warner
(Informant)
(Address) 1411 Decatur St

15- MAY 25 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 23-24

17- I HEREBY CERTIFY, That I attended deceased from May 23 19 24 to May 23 19 24
that I last saw him alive on May 23 19 24
and that death occurred, on the date stated above at ..... m.
The CAUSE OF DEATH* was as follows: Oedema of Lung

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Ch Dis Kidneys

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Jno G Silverman M. D.
19 (Address) 11 Newcomb St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 5/26 19 24
20-UNDERTAKER J. F. Thorpe & Son	ADDRESS 3720 Eight Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87281

CERTIFICATE OF DEATH.

D 87281

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 3 WARD)

2-FULL NAME Frank Duvall

(a) RESIDENCE. No. 921 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Municipal Hospital Read

15 Filed MAY 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-7, 1924, to 5-21, 1924, that I last saw him alive on 5-21, 1924, and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Generalized Carcinomatosis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sat. + Autopsy

(Signed) Claude S. Drace, M. D.

5-21 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	24 May 1924
20 UNDERTAKER	ADDRESS
J. J. Daley & Son	1318 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87282

CERTIFICATE OF DEATH.

57 D 87282

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 200-A South Bellair Road ST., 27 WARD)

2-FULL NAME E. Elizabeth Morgan.

(a) RESIDENCE NO. 200-A. S. Belair Road ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Morgan.

6 DATE OF BIRTH (month, day, and year) Feb. 15. 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edw. Willing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Shenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant J. Calvin Morgan

(Address) 5216 Florence Ave

15 MAY 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23. 1924

17

I HEREBY CERTIFY, That I attended deceased from March 25. 1924. to May 23. 1924.

that I last saw h. alive on May 16. 1924

and that death occurred, on the date stated above, at 6. P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Nephritis & Uremia

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wilbur Tompkins M. D.

(Address) 6 Randall Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL May 26 1924

20 UNDERTAKER Mr. & Mrs. John N. Teufel & Son — ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87283

CERTIFICATE OF DEATH.

7/132 D 87283

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Southall

(a) RESIDENCE NO. Amelia Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 13 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	71	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Judge
(b) General nature of industry, business, or establishment in which employed (or employer) 042
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER R. T. Southall

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Eliz J. Brade

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 26 1924 Registrar
HUBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1924, to May 26, 1924, that I last saw h[illegible] alive on May 26, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Pyelonephritis.
Cardiac failure

..... (duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Benign Prostatic hypertrophy
Surgical catheters (duration) 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Feb 1924

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Amelia Courthouse Va — DATE OF BURIAL May 26 1924

20 UNDERTAKER J. E. Mitchell — ADDRESS 1201 W Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87284

CERTIFICATE OF DEATH.

90 D 87284

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home Infirmary

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Mr. Frederick Franz

(a) RESIDENCE NO. 2113 N. Calvert ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nellie A Franz.

6 DATE OF BIRTH (month, day, and year) Jan 31. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agt 12

(b) General nature of industry, business, or establishment in which employed (or employer) Life Insurance

(c) Name of employer Reynolds & Franz

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Franz

11 BIRTHPLACE OF FATHER (city or town) Bdlfo
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary O Kaufman

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Nellie G Franz
(Address) 2113 No Calvert St

15 MAY 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 4 1924 to May 23 1924.

that I last saw h in alive on May 23 1924

and that death occurred, on the date stated above, at 6:30P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Doubtful mos ds.

CONTRIBUTORY (Secondary) Bricarditis - auty

(duration) yrs. mos 5 wks

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. E. Rice M. D.

, 19 (Address) Church Home Bty

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL May 26 1924

20 UNDERTAKER W. E. Cook — ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Brumbach 1531 8 North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87285

CERTIFICATE OF DEATH.

31 D 87285

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 601 Cator Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence E Cully

(a) Residence No. 601 Cator Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: W.

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 25. 1897

7-AGE, 26 yrs. 9 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Trained Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer:

9-BIRTHPLACE (city or town). (State or Country), Penna

PARENTS.

10-NAME OF FATHER: Oscar D Cully

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Penna

12-MAIDEN NAME OF MOTHER: Hettie Kendig

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Penna

14- (Informant) Oscar D Cully

(Address) 601 Cator Ave

MAY 26 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to May 24, 1924, that I last saw h alive on May 22, 1924, and that death occurred, on the date stated above, at 3.0 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Unsigned

(Signed) J E Burnbach M. D.

5-24-1924 (Address) 1531 2 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Hartsville, Penna — DATE OF BURIAL, May 27, 1924

20-UNDERTAKER: W. Cook — ADDRESS 502 E Fayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87286

CERTIFICATE OF DEATH.

74-001 D 87286

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 E Potomac ST., 1 WARD)

2-FULL NAME Louisa M. Schuck

(a) RESIDENCE NO 815 E Potomac ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George L. Schuck

6 DATE OF BIRTH (month, day, and year) Dec 10 1858 Inquiry

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	5	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) ooo
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Roderick Fleming

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Beinroth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant William F. Schuck
(Address) 815 E Potomac St

15 Died MAY 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo E Blades, M. D.
5/24/24 (Coroner.)
(Address) 143 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Cemetery	May 26 1924
20 UNDERTAKER	ADDRESS
H. Sander Sons	120 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bka.

D 87287.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D 87287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Taylor

(a) RESIDENCE NO. 2005 Etting St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Dec 5/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Taylor

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Janey Brown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Virgie Ringhold
(Address) 1463 N. Carey St

15 Filed MAY 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Autopsy At Hopkins)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) ... yrs. ... mos. ... ds.

(Signed) J. S. Baer, M. D.
(Coroner.)

May 26/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 26 1924

20 UNDERTAKER Jesse Redden — ADDRESS 424 Biddle St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

87288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87288

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1450 Parrish St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary Smith

(a) Residence No..... 1450 Parrish St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879

7-AGE. 45 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Car Cleaner

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 086

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Md

PARENTS.

10-NAME OF FATHER. Alston Kyler

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Brown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Md

14-

(Informant)..... Mary Kyler

(Address) 1450 Parrish St

15- MAY 26 1924

Robert R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-24-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan, 1923, to May 24, 1924, that I last saw h[e] alive on May 22, 1924, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH* was as follows:

Aneurysm of aorta

(Duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? X Ray - Hospitalization

(Signed) Evan J. Magruder, M. D.

5/26, 19 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, 5-26-, 19 24

20-UNDERTAKER. Daniel Taylor

ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87289

CERTIFICATE OF DEATH.

400-001

D 87289

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 9 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Gamble

(a) RESIDENCE No. 920 E. 30th St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or .. min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) -

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed MAY 26 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-14, 1922 to 5-25, 1924, that I last saw him alive on 5-24, 1924, and that death occurred, on the date stated above, at 8 45 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Path.

(Signed) Claude G. Hance, M. D.

5-25-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Cemetery Broadway & [illegible]	May 27 1924
20 UNDERTAKER	ADDRESS
Johannah Carole	[illegible]

Spec.—1-10-21—M&T—1500 Bks.

D 87290 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D 87290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 N Pine ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George P. Langford

(a) RESIDENCE NO. 312 N Pine St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Langford

6 DATE OF BIRTH (month, day, and year) May 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Langford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Amanda Langford (Address) 312 N Pine St

15 Filed ... 19 ... ROBERT R. KRAUPER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924 to May 21 1924.

that I last saw him alive on May 20 1924

and that death occurred, on the date stated above, at 9.50 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

Duration Treated ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) W. H. Howell M. D.

May 26 1924 (Address) 114 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL May 26 1924

20 UNDERTAKER Samuel S. Newsley ADDRESS 1 Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87291

D 87291

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 E Preston St ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard LaWalle Taylor

(a) RESIDENCE No. 2309 E Preston St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Taylor

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Decker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Walter C Bacon (Address) 100 E 20th St Balto Md

15 MAY 26 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 23, 1924, that I last saw him alive on May 23, 1924 and that death occurred, on the date stated above, at 10. ..... m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Probably Tubercular Meningitis

..... (duration) ..... yrs. ..... mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Those of Pneumonia

(Signed) [redacted] Walter C Bacon, M. D.

5/23/24 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL May 26, 24

20 UNDERTAKER James B Ayres — ADDRESS 1374 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87292

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87292

CERTIFICATE OF DEATH

191-001

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Levin

(a) RESIDENCE NO. 910 E Druid Hill Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White Hebrew.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25, 1924

7 AGE	Years	Months	Days	If LESS than 1 day..Hrs. or.....min.
		7½ mos Intrauterine		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Levin

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Diner

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Mrs. Rebecca Levin (Address) 910 E Druid Hill Ave

15 MAY 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from 12 45 a. m. May 25, 1924, to 11 a. m. May 25 1924.

that I last saw him alive on May 25 1924.

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity. (7½ or 8 mos)

about 1 hr

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Abruptio Placenta

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 25 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Townsend Neal, M. D.

, 19 (Address) MD Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash. Grad

DATE OF BURIAL May 26 1924

20 UNDERTAKER Jack Levin

ADDRESS 1439 E. Balto

Spec.—1-10 21—M&T—1500 Bks.

D 87293

HEALTH DEPARTMENT—CITY OF BALTIMORE

1291 D 87293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. St. or Ave. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Cartlouff Jr.

(a) RESIDENCE NO. 1006 W Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	6	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va
(State or country)

PARENTS

10 NAME OF FATHER Herbert S. Partlow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Diana Dulaney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Herbert S. Partlow
(Address) 1006 W. Fayette St

15 MAY 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25- 1924

17

I HEREBY CERTIFY, That I attended deceased from 5-12, 24, to 5-25, 1924,

that I last saw him alive on 5-25, 1924,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse nephritis

(duration) yrs. 1 mos 13 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo A Dempsey M. D.

, 19 (Address) MD Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leeds Va	May 28 1924
20 UNDERTAKER George J Smith	ADDRESS 532 Hollins

Cor.—1-12-23—M&T—100 Bks.

D 87294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87294

CERTIFICATE OF DEATH.

74-001

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Ramsey ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leo W. Emerson

(a) RESIDENCE NO 707 Ramsey ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Gov't
(c) Name of employer

9 BIRTHPLACE (city or town) Balt md
(State or country)

PARENTS

10 NAME OF FATHER Ed Emerson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Dyson

13 BIRTHPLACE OF MOTHER (city or town) Balt City
(State or country)

14 Informant Mrs Sadie Buck
(Address) 707 S Ramsey

15 MAY 26 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(duration) a few hours

CONTRIBUTORY (Secondary) Don't Know
(duration) yrs. mos. ds.

(Signed) W. R. Douglas, M. D.
(Coroner)
5-26, 1924 (Address) 1117 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL May 27 1924

20 UNDERTAKER John J Cavan & Son — ADDRESS 9 & Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Blks.

D 87295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D 87295

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 945 N. Castle ST., 7 WARD)

2-FULL NAME George Cummings

(a) RESIDENCE NO. 945 N. Castle ST., 7 WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Ella L Cumming

6 DATE OF BIRTH (month, day, and year) Oct 28 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 086

(b) General nature of industry, business, or establishment in which employed (or employer) City work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md Calvert

PARENTS

10 NAME OF FATHER Cumming

11 BIRTHPLACE OF FATHER (city or town) Calvert. (State or country) Md

12 MAIDEN NAME OF MOTHER Cumming

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Ella L Cumming
(Address) 945 N Castle st

15 MAY 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 7 24, 1924, to May 23, 1924,

that I last saw him alive on May 21, 1924,

and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) " "

(duration) yrs. mos. " ds.

18 Where was disease contracted
If not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? physical

(Signed) Geo. Keller, M. D.

May 24, 19 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL May 26 1924

20 UNDERTAKER Robt J Turner Jred — ADDRESS 1442 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87296

CERTIFICATE OF DEATH.

90

D 87296

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1411 W. 25 St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel B Cunningham

(a) Residence No. 14 W. 25 St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: James S Cunningham

6-DATE OF BIRTH (month, day and year): Dec 14 1865

7-AGE: 58 yrs. 5 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: house duties

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Mass

PARENTS.

10-NAME OF FATHER: Nathaniel G. Sexton

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Mass

12-MAIDEN NAME OF MOTHER: Eliz. P. Hamblin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14-Informant: James S. Cunningham

Address: 14 W. 25 St.

15-Filed MAY 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 24 24

17- I HEREBY CERTIFY, That I attended deceased from May 22 19 24 to May 24 19 24

that I last saw h[illegible] alive on May 24 19 24

and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. some mos. ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank M Smith M. D.

May 24 19 24 (Address) 1 & 35 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL, May 27 1924

20-UNDERTAKER: John O'Neill ADDRESS 120 W. Fayette St.

IMPORTANT—PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 187297 ~~187~~3

CERTIFICATE OF DEATH.

5 V D 87297

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 1 WARD)

2-FULL NAME Isabella Green

(a) RESIDENCE NO. 1341 E Carroll ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Green

11 BIRTHPLACE OF FATHER (city or town) D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Emery Roy

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records JOHNS HOPKINS HOSP.
(Address) ROBERT R. KRAUTER,

15 Filed MAY 26 1924 19 Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17

I HEREBY CERTIFY, That I attended deceased from May 12 1924 to May 23 1924

that I last saw h alive on May 23 1924

and that death occurred, on the date stated above, at 1 15 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Rheumatic endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Bagg M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Grove Cem	May 26 1924
20 UNDERTAKER Wm R A Elliott	ADDRESS 1723 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

D 87298

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87298

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N. Bond ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa Hawkins

(Residence in Baltimore: No. 1008 N. Bond St St.; 57 yrs., 11 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, June (Month) 24 (Day), 1866 (Year)

7-AGE, 57 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John O'Malley

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Theresa O'Malley

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William L. Mullen M.D

(Address) 1020 N. Calvert St

15- MAY 26 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1923, to May 25 1924, that I saw her alive on May 22 1924, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) 9 yrs. mos. ds.

(Signed) William L. Mullen M. D.

May 25., 1924 (Address) 1020 N. Calvert St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery

DATE OF BURIAL, May 26, 1924

20-UNDERTAKER Henry Hoen Son

ADDRESS 1201 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 87299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 87299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1505 W. Saratoga ST., 19 WARD)

2-FULL NAME Lillian May Jackson

(a) RESIDENCE NO. 1505 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. ....min.
	=	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER Columbus Jackson

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bayton

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mary Jackson
(Address) 1505 W Saratoga St

15 MAY 26 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) = yrs. = mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Geo. B. Norton, M. D.
(Coroner.)

May 25, 1924 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	5/27 1924
20 UNDERTAKER Mrs Jas H. Dennis	ADDRESS 1303 Presstman St

NOTE—WARNING—PENALTY FOR FALSE RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87300 **CERTIFICATE OF DEATH.** 22 24 31 D 87300

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter White

(a) Residence No. 100 Key Highway St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Singl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of 1903

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day,
21 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Waiter 070
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown

9-BIRTHPLACE (city or town) .....
(State or Country). Maryland

PARENTS:
10-NAME OF FATHER. David White
11-BIRTHPLACE OF FATHER (city or town) .....
(State or Country). Indiana
12-MAIDEN NAME OF MOTHER. Molly Terhune
13-BIRTHPLACE OF MOTHER (city or town) .....
(State or Country). Indiana

11- (Informant) Hospital Records
(Address) M.T.H.

MAY 26 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1924 to May 20, 1924, that I last saw him alive on May 20, 1924, and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray.

(Signed) L. A. Lally M. D

5-20. 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ..... 19..
20-UNDERTAKER.	ADDRESS

UNIVERSITY OF MARYLAND MAY 24 1924

For Wm. H. Welch

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87301 CERTIFICATE OF DEATH. 32 D 87301

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Houston Sanders

(a) Residence No. 120 Dover Stret St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colred	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day,
29 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffeur

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Tennessee

PARENTS.

10-NAME OF FATHER, Wm. Sanders

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Tennessee

12-MAIDEN NAME OF MOTHER, Cenella Sanders

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Carwandall Illinois

14- (Informant)

(Address)

15- Filed MAY 26 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1924 to May 20, 1924, that I last saw him alive on May 20, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Hepatitis

(Duration) yrs. 7 mos. days.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical Findings

(Signed) Wm. J. Sutton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or if deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, 19
20-UNDERTAKER.	ADDRESS

STATE OF MARYLAND MAY 24 1924 Commissioner Health.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM REQUIRED should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87302

CERTIFICATE OF DEATH.

10 D 87302

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2106 Herbert St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Edith F. Fleetwood

(a) Residence No. 2106 Herbert St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
F	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 8 1915

7-AGE. 8 yrs. 9 mos. 16 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER Wm Fleetwood

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER Mary Kebaugh

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14- (Informant) Wm Fleetwood

(Address) 2106 Herbert St

15- Filed MAY 26 1924 19.. ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 23 1924

17- I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 24, 1924, that I last saw her alive on May 24, 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diptheria

and Broncho-Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Health Dept - Culture

(Signed) Francis N. Ogden, M. D.

May 26, 1924 (Address) 43 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Wards Chapel	May 26, 1924

20-UNDERTAKER CHENOWETH & SON ADDRESS 3617 CHESTNUT AVE.

Spec.—1-10-21—M&T—1500 Bks.

Infant Kennedy.

87303

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-001 D 87303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S. Ellwood Ave ST., 1 WARD)

2-FULL NAME Boy (Premature Birth)

(a) RESIDENCE No. 708 S. Ellwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 14 hrs. & 25 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William J. Kennedy

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Helen Taylor

13 BIRTHPLACE OF MOTHER (city or town) Kent Co (State or country) Md

14 Informant William J. Kennedy (Address) 708 S. Ellwood Ave

MAY 26 1924 Filed ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1924, to May 25, 1924, that I last saw him alive on May 25, 1924, and that death occurred, on the date stated above, at 10 1/2 m.

The CAUSE OF DEATH* was as follows:

Premature Birth, 8th Month

Lived 14 hrs & 25 Min

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. Z. Packard M. D.

5-26-1924 (Address) 5100 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	May 27 1924
20 UNDERTAKER Penkler & Penkler	ADDRESS 1238 E. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001 ✓

D 87304

CERTIFICATE OF DEATH.

D 87304

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 Ducatel St. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Moses Bass

(a) Residence No. 903 Ducatel St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write which.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 23, 1870

7-AGE. 54 yrs. 10 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk-American

(b) General nature of industry, business, or establishment in which employed (or employer) Can Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town). Calvert County

(State or Country). Md.

PARENTS.

10-NAME OF FATHER Abraham Bass

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Caroline Gump

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant) Mrs. Sol. Bass

(Address) 903 Ducatel St.

15- Filed MAY 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/25/24.

17- I HEREBY CERTIFY, That I attended deceased from May 4, 1923, to May 24 19.24.

that I last saw him alive on May 24, 19.24,

and that death occurred, on the date stated above, at 4.15 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood Examination

(Signed) Edwin E. Mengert, M. D.

5/25, 1924 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oheb Shalom Cem. DATE OF BURIAL, 5/27/1924.

20-UNDERTAKER, David Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 87305

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1112 Hasselberger St. 23 WARD)

2-FULL NAME Samuel Comish

(a) RESIDENCE No. 1112 Hasselberger St. 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Comish

6 DATE OF BIRTH (month, day, and year): 1865

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Hostler

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Samuel Stafford

(Address) 817 Union St.

15 Filed MAY 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/19/ 1924, to 5/25/ 1924, that I last saw h alive on 5/25/ 1924, and that death occurred, on the date stated above, at 2.40 p. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis,

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no,

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

5/24/ 1924 (Address) 908 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: May 27 1924

20 UNDERTAKER: J. H. V. Brown & Son

ADDRESS: 108 N. Monty

Spec.—1-10-21—M&T—1500 Bks.

987306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87306

CERTIFICATE OF DEATH.

100-00

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert-Saratoga ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Drawn

1a) RESIDENCE NO. 1914 N Fulton Av ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip Drawn

6 DATE OF BIRTH (month, day, and year): Aug 9 1897

7 AGE — Years: 26 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Chi, Illinois

PARENTS

10 NAME OF FATHER: unknown Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mr Philip Drawn

(Address): 1914 N Fulton Ave.

15 [illegible]

MAY 26 1924

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to May 25, 1924, that I last saw her alive on May 25, 1924, and that death occurred, on the date stated above, at 2.17 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Pancarditis with effusion (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Kyle W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Stamford Conn

DATE OF BURIAL: May 28 1924

20 UNDERTAKER: John J Cowan & Son, Cert'd F J Cowan

ADDRESS: 301 Holley St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D 87307

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

D 87307

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Cross

(a) Residence No. 707 N. Fayette, City St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, N.

5-~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cuneo

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 52. yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED.

(a) Trade, profession, or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) 106

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). " "

14- (Informant) Cuneo & Co.

(Address) 122 N. Rosedale St.

MAY 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 23 1924

17- I HEREBY CERTIFY, That I attended deceased from May 7, 1924, to May 23, 1924,

that I last saw h... alive on May 23, 1924

and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of Lung

(Duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray.

(Signed) S. Goldman, M. D

19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral	May 27, 19 24
20-UNDERTAKER.	ADDRESS
Kendle Bryan Co.	875 N.

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Exact statement of OCCUPATION is very important. See

should be carefully supplied. AGE should be stated

Spec.—8-24-14—M. & T.—2000 Bks.

D 87308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 87308

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 Madison Ave 3-d floor ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Cook

(Residence in Baltimore: No. 1930 Madison Ave St.; ....yrs., ...mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Baby

6-DATE OF BIRTH, May (Month) 22 (Day), 1924 (Year)

7-AGE, ...yrs. 20 hrs 2 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Baby
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Anthony L. Cook

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Ida B Brennan

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John B Cook

(Address) 1930 Madison Ave

15-

MAY 26 1924

Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1924, to May 25 1924, that I saw him alive on May 24 1924, and that death occurred, on the date stated above, at 10.1 m.

The CAUSE OF DEATH* was as follows:

(a) Asthenia

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Thos A Schaefer M. D.

May 25, 1924 (Address) 1103 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs....mos....ds. In the State ....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, JOHNS HOPKINS HOSPITAL — DATE OF BURIAL, ..., 192..

20-UNDERTAKER Commissioner Health. — ADDRESS MAY 26 1924

For Wm. R. WOODALL

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87309 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87309

CERTIFICATE OF DEATH

117

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE. (No.) 2735 N. Northwest ST. 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl. I. Burgess.

(a) RESIDENCE No. 2735 N. Northwest ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., If of foreign birth? 36 yrs. 8 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Francis P. Burgess.

6 DATE OF BIRTH (month, day, and year): Aug 27. 1887.

7 AGE — Years: 36. Months: 8. Days: 27. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Maryland.

PARENTS

10 NAME OF FATHER: Francis M. Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co. Maryland.

12 MAIDEN NAME OF MOTHER: Josephine Conaway.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co. Maryland.

14 Informant (Address): Francis P. Burgess. 2735 N. North Ave.

15 Filed ..... 19 ..... Registrar

MAY 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1924, to May 24, 1924, that I last saw her alive on May 24, 1924, and that death occurred, on the date stated above, at 9.45 A.m.

The CAUSE OF DEATH* was as follows:
Acute Gastric Dilatation, following operation for Cystectomy and appendectomy

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 19. 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) C. W. Hoffman M. D.

5/24, 1924 (Address) 1102 No. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery. DATE OF BURIAL: May 27. 1924

20 UNDERTAKER: Walter Davis ADDRESS 3307. Paine St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87310

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4708 Charles ave. ST., Lauraville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine E. Kidd

(a) RESIDENCE No. 4708 Charles ave. ST., Lauraville WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23rd 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Milliner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hutzler Bros. Balto.

086

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Kidd

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Judith Epple

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Frank Kidd

(Address) 4708 Charles Ave. Lauraville

MAY 26 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 , 19 24 , to May 25 , 19 24 ,

that I last saw him alive on May 25 , 19 24 ,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Cleaning

acute

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Lee Jones, M. D.

5/26 19 24 (Address) 4702 Harper

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 28 1924
20 UNDERTAKER	ADDRESS
Fredk Lockhart Sons	Fullerton

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 8731F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8731F

CERTIFICATE OF DEATH

161-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Hanover ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Pratt.

(a) RESIDENCE. NO. 702 Hanover st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. md.
(State or country)

PARENTS

10 NAME OF FATHER Herman Pratt

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie Richardson

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Parent (mother) JOHNS
(Address) 702 Hanover st

MAY 26 1924

, 19 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5. 22. 1924

17 I HEREBY CERTIFY, That I attended deceased from 5. 22, 1924, to 5. 22. 24, 19, that I last saw h 4 alive on 5. 22. 24, 19, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(5 mos. fœtus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Norris, M. D.

5. 22. 1924 (Address) 107 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOPKINS HOSPITAL.	MAY 23 1924

20 UNDERTAKER Commissioner Health.

ADDRESS

Per. Wm. A. Wood.

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D187312

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87312

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME William Heffernan

(a) RESIDENCE NO. 643 S. W. 11th St ST. Miami, Fla WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	14	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fla

PARENTS

10 NAME OF FATHER Father

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Irma Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

Robert F. Harrison

Assist. Permit Clerk.

MAY 26 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 26, 1924, that I last saw him alive on May 26, 1924, and that death occurred, on the date stated above, at 2 50 P m.

The CAUSE OF DEATH* was as follows:

Acute Secondary Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Rhinopharyngitis

(duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jas. R. Bugg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Miami Fla	May 26 1924
20 UNDERTAKER	ADDRESS
Joseph Ahern	221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87313

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Chandler

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 29 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	27	

8 OCCUPATION OF DECEASED Ladies Tailor

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Harvey? Chandler

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Elya Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Municipal Hospital Reno (Address)

15 Filed MAY 28 1924 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-8 1924, to 5-25 1924, that I last saw him alive on 5-25 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

.....(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

.....(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ext.

(Signed) Claude E. Jones, M. D.

5-26 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Sect O Cive DATE OF BURIAL MAY 27 1924

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87314

CERTIFICATE OF DEATH.

X 118-002

1-PLACE OF DEATH U.S Marine Hospital #1.
Baltimore, Md.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Diggs

(a) RESIDENCE NO. U.S Marine Hospital St., Ward Virginia
(Usual place of abode) Baltimore Md (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of: Katherine M. Diggs

6 DATE OF BIRTH (month, day, and year): Oct 18 1850

7 AGE: Years 73 Months 7 Days 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer): Captain
(c) Name of employer: S/S Alabama

9 BIRTHPLACE (city or town) (State or country): ~~Southampton~~ Virginia

PARENTS

10 NAME OF FATHER: John H. Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary C. Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Self
(Address)

15 MAY 26 1924 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to May 25, 1924 that I last saw him alive on May 25 1924, and that death occurred, on the date stated above, at ~~—~~ 11 20 a.m.

The CAUSE OF DEATH* was as follows: Paralytic, Ileus

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. C. Graves, M. D.

19 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Williams Wharf, Matthews Co Va

DATE OF BURIAL: MAY 27 1924 19

20 UNDERTAKER: Geo W. Little

ADDRESS 2700 Edmondson Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87315

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 455 Pinkney ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Miller

(a) RESIDENCE No. 455 Pinkney ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) March 26/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Baby.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William E Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conoly Co Va. -

12 MAIDEN NAME OF MOTHER Gertrude Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant William E Miller (Address) 455 Pinkney St

15 MAY 26 1924 Robert F. Harrison, Registrar. 19 ..... Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25-1924

17 I HEREBY CERTIFY, That I attended deceased from 5-24, 1924, to 5-25, 1924, that I last saw h alive on 5-25, 1924, and that death occurred, on the date stated above, at ..... P m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Dr Bernard Lord, M. D.

5/26 1924 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	5-27 1924
20 UNDERTAKER	ADDRESS
E. C. Weidefeld	501 E 22nd St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks. Ten 5784

D. 87316 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D. 87316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 15-100

City of BALTIMORE: (No. 3404 Cordiler St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Ray Roberts

(a) Residence No. 3404 Cordiler St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Herbert C Roberts

6-DATE OF BIRTH (month, day and year) May 4 1887

7-AGE	If LESS than 1 day
36 yrs. 0 mos. 18 ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Geo McQuilkin

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Mr Herbert C Roberts

(Address): 3404 Cordiler Ave

15- Filed 1924 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 25 - 1924

17- I HEREBY CERTIFY, That I attended deceased from May 11th 1924 to May 25 1924

that I last saw h. alive on May 24th 1924

and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Purulent Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Purulent Bronchitis

(Duration) 0 yrs. 0 mos. 15 ds.

18-Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none —

(Signed) Gordon Wilson M. D

, 19 (Address) 4 E. Preston St.,

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Druid Ridge Cem	May 28 1924
20-UNDERTAKER.	ADDRESS
Wm Fleckner Sons	North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 87317

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 9 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Charles F. Wehr

(a) Residence No. 1516 Holbrook st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1902 age 26

7-AGE. 21 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Electric cutter

(b) General nature of Industry, business, or establishment in which employed (or employer)... Unknown

(c) Name of employer... Unknown

9-BIRTHPLACE (city or town) (State or Country). New York

PARENTS.

10-NAME OF FATHER, Charles P. Wehr

11-BIRTHPLACE OF FATHER (city or town) (State or Country). New York

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). New York

14-

(Informant)... Hospital Records

(Address)... M.T.H.

15-

Filed MAY 26 1924 Robert P. Harrison Registrar.

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 19 1923 to May 24 1924

that I last saw him alive on May 24 1924

and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally, M. D

5-24, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cem'ty	May 27 24
20-UNDERTAKER,	ADDRESS
George J. Rust	1735 Harford Ave

U.S. Certificate of Death. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should give NAME OF HOSPITAL, if death occurred in one. Information should be carefully supplied. Exact statement of OCCUPATION is very important. Statements should be in plain terms, so that it may be properly classified. Physicians are requested to write plainly. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 37318 HEALTH DEPARTMENT—CITY OF BALTIMORE D 37318

CERTIFICATE OF DEATH. 82

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad H. Ludwig

(a) RESIDENCE NO. 702 Cumberland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Elizabeth M. Ludwig

6 DATE OF BIRTH (month, day, and year) July 8 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 0/2

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. M. Ludwig

(Address) 702 Cumberland

Filed ... 19 ... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1924

17

I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1924, to May 24, 1924,

that I last saw him alive on May 24, 1924,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Toxic Psychosis

Multiple Neuritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) circulatory factors.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home (?)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed) James S. White, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cem	May 27 19 24
20 UNDERTAKER	ADDRESS
Wm J. Treasurer Sons	Northern

3.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 26 1924

Cor.—1-12-23—M&T—100 Blks.

Dr Bloedes
1300 Eutaw-Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87319

CERTIFICATE OF DEATH.

181-001

D 87319

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Guilford Ave & Pleasant Street WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McBride

(a) RESIDENCE NO. Guilford Ave & Pleasant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah McBride

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lighting Rod
(b) General nature of industry, business, or establishment in which employed (or employer) Maker
(c) Name of employer Himself

1886

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James McBride

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah McBride
(Address) 127 So. Ford St

Filed MAY 26 1924, 192 Robert F. Duffy Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc
Gas (Illy) Poisoning
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis
(Duration) yrs. mos. ds.

(Signed) Geo Clinton Peed, M. D.
(Coroner.)

5/26/24, 192 (Address) 145 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 5/28 1924

20 UNDERTAKER William Cook — ADDRESS 502 E North

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important! See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87320

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87320

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Baby Moberly

(a) RESIDENCE NO. 2712 Winchester ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 6½ mos. ..... ds. Intrauterine

(If non-resident give city or town and State)

How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26, 1924

7 AGE — Years: ..... Months: 6½ Intrauterine Days: ..... If LESS than 1 day, 4 hrs ~~or ..... min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William M. Moberly

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary M. Butler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant (Address) Wilbur M. Moberly 2712 Winchester St

15 Filed MAY 26 1924, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I attended deceased from 8.00 A.M. May 26, 19 24, to 12 M May 26, 19 24

that I last saw him alive on May 26, 19 24

and that death occurred, on the date stated above, at 12.00 m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ mos)

(duration) ..... yrs. ..... mos 4 hrs. ..... ds.

CONTRIBUTORY (Secondary) Premature Separation of Placenta (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Thos A Dougherty, M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: May 27 1924

20 UNDERTAKER: W. Cook — ADDRESS: 502 E Fayette

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 8732E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8732E

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 E Madison St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Young

(a) RESIDENCE NO. 1635 E Madison St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	approx 42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas W. Young

11 BIRTHPLACE OF FATHER (city or town) R.D.,
(State or country)

12 MAIDEN NAME OF MOTHER Mariah J. Waters

13 BIRTHPLACE OF MOTHER (city or town) R D
(State or country)

14 Informant Estes Alston (sister)
(Address) 1635 E Madison St

MAY 26 1924

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1924, to May 25 1924,
that I last saw him alive on May 23 1924,
and that death occurred, on the date stated above, at 7 05 A m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (Chronic)

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R J Young, M. D.

5/26 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL 5/27 1924

20 UNDERTAKER Jos Inv Skinner ADDRESS 1425 E Madison St

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87322

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2911 E Baltimore St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick H. Klepper

(a) Residence No. 2911 E. Baltimore St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 4 mos. 26 ds. How long in U. S., if of foreign birth? 39 yrs. 4 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 30th 1884

7-AGE. 39 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Compositor

(b) General nature of industry, business, or establishment in which employed (or employer) 63

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Chas F Klepper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna A Lange

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Anna A Klepper

(Address) 2911 E Baltimore

15- Filed ..... 192.....

Registrar.

MAY 26 1924

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 25 1924

17- I HEREBY CERTIFY, That I attended deceased from March 30 1924 to May 25 1924

that I last saw h.. alive on May 24 1924

and that death occurred, on the date stated above, at 12 40P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Nov 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Col Norris M.D.

May 26 1924 (Address) 274 E 30th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cem DATE OF BURIAL, May 28th 1924

20-UNDERTAKER, Peter Nicolaus ADDRESS 2160 Eastern Ave

Instructed EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87323 HEALTH DEPARTMENT—CITY OF BALTIMORE R 87323

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

City of BALTIMORE, (No. 2900 Kate Ave St. 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Nathaniel Nunsen

(a) Residence No. 2900 Kate Ave St., 15 Ward Resident
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? 71 yrs. 6 mos. 24 ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Grace A. Nunsen

6-DATE OF BIRTH (month, day and year) Nov-1-1852

7-AGE, 71 yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work President

(b) General nature of industry, business, or establishment in which employed (or employer) Nunsen Sons Co.

(c) Name of employer Self

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John H. Nunsen

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Leppela

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs Grace A. Nunsen (wife)

(Address) 2900 Kate Ave.

15- Filed Robert P. Harrison, Registrar.

MAY 26 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 25-24

17- I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to May 24, 1924, that I last saw h~~im~~self alive on May 23, 1924 and that death occurred, on the date stated above, at 8:10 A.m.

The CAUSE OF DEATH* was as follows: Myocarditis, Bright's Disease, Uremia about (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) ~ (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Blood Test

(Signed) Julius Friedenwald, M. D.

, 19 (Address) 1013 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL, May-26 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS s
In plain terms, so that it may be properly classified. Exact statement of OCCUI
instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87324 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87324

CERTIFICATE OF DEATH.

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 111 W. Franklin St. 4 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Melvina Hazazer

(a) Residence No. 111 W. Franklin St. St., 4 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 80 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Hazazer

6-DATE OF BIRTH (month, day and year) About 1860

7-AGE, About 80 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town). (State or Country), Philadelphia Penna.

PARENTS.

10-NAME OF FATHER. Samuel Hunt

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Philadelphia Penna

12-MAIDEN NAME OF MOTHER. Catherine Hall

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Philadelphia Penna

14- (Informant) Miss Florence E. Hazazer

(Address) 111 W. Franklin St.

15- Filed MAY 26 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/26/24

17- I HEREBY CERTIFY, That I attended deceased from March 24 1924 to May 26 1924,

that I last saw h[illegible] alive on May 24 1924,

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

chronic interstitial nephritis

& bronchial asthma

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ima. Tama

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Thomas, M. D.

5-26 1924 (Address) 804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Philadelphia Pa. DATE OF BURIAL. May 30th 1924

20-UNDERTAKER. STEWART & BROWN COMPANY (William F. Wooden, Successor) ADDRESS 108 W. North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sl... in plain terms, so that it may be properly classified. Exact statement of OCCUP... instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87325

CERTIFICATE OF DEATH.

D 87325

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 N. Stockton St. 15 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael J. Flannery

(a) RESIDENCE NO. 1329 N. Stockton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Flannery.

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Flannery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louis Flannery
(Address) 1329 N. Stockton St.

Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of humerus (Fell over a dog).

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chr. Inter. Nephritis

(duration) yrs. 4 mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

May 26, 1924 (Address) 28 Courtland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL May 29 1924

20 UNDERTAKER M. Fahey & Sons

ADDRESS 1827 W. Fayette

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

172 15 D 87326

106-901 D 87326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 6 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Taylor

(a) RESIDENCE No. 419 N. Bond ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~Husband of~~ (or) WIFE of Henry Taylor

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Reads
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar
MAY 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 24, 1924, that I last saw her alive on May 24, 1924, and that death occurred, on the date stated above, at 12 55 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Lung abscesses

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Walter B. Stewart M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leaksburg Cemetery	May 27 1924
20 UNDERTAKER	ADDRESS 1631 St
Edward Bryson & Sons	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87327

CERTIFICATE OF DEATH.

57 D 87327.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Butler

(a) RESIDENCE NO. 410 New ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victoria Butler

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE — Years: 46 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hotel Prop.

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: George Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Stafford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Victoria Butler (Address) 1527 Myrtle Ave

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1924

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to May 24, 1924

that I last saw him alive on May 24, 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows: Miliary Infiltration of Lachis Rectal Abscess

(duration) ..... yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? 410 New St

Did an operation precede death? Yes Date of May 19

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 1413 E. Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 27 24

20 UNDERTAKER: Frank Wensley — ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

87328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 87328

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brown

(a) RESIDENCE NO. 1126 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Brown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 MAY 27 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25-1924

17

I HEREBY CERTIFY, That I attended deceased from 8-29, 1923, to 5-25, 1924, that I last saw him alive on 5-24, 1924, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Syphilis

C.N.S. Syphilis (General Paresis)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude S. Grace, M. D.

5-25 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL May 28

20 UNDERTAKER Samuel Hawley ADDRESS 1 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87329

CERTIFICATE OF DEATH.

D 87329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Druid Hill Ave. St., 14 WARD)

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hawkins

(a) RESIDENCE NO. 211 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Hawkins

6 DATE OF BIRTH (month, day, and year) about 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Cook
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Taubmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Taubmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lewis Hawkins
(Address) 508 N. Carey St.

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

May 25, 1924 (Address) 238 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 27 '24
20 UNDERTAKER Edward D. Hawley	ADDRESS 1 E. Eddy

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87330

CERTIFICATE OF DEATH.

D 87330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Carrollie St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. Briggs Jr

(a) RESIDENCE NO 112 S Carrollie St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred N yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie Briggs

6 DATE OF BIRTH (month, day, and year): Mar, 28-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	38		28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clearder
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va

PARENTS

10 NAME OF FATHER: John Briggs Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hattie Briggs
(Address) 230 Hamburg St

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

AC Indigestion
Coma Fatal
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema
(duration) yrs. mos. ds.

(Signed) Geo Edwin Blake M. D.
(Coroner)
May 23 1924 (Address) 143 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 28 1924

20 UNDERTAKER: David S. Hunsley — ADDRESS: Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8733E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 ✓

D 8733E
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Pear St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Jessie Bradford

(a) Residence No. 920 Pear St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Fem.	Col.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jany 2 1890

7-AGE,	If LESS than 1 day,
34 yrs. 5 mos. 22 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... Laundress
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country).

PARENTS.

10-NAME OF FATHER, Geo. Bradford

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country).

12-MAIDEN NAME OF MOTHER, Fannie Peaker

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country).

11- Clara Bradford
(Informant)
920 Pear St
(Address)

MAY 27 1924

ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 24 24

17- I HEREBY CERTIFY, That I attended deceased from Mar 3, 1924, to May 24 1924, that I last saw her alive on May 23, 1924, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Intoxication

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Norman Murray M.D.

5-26, 1924 (Address) 1 E Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Md	May 29 1924
20-UNDERTAKER.	ADDRESS.
Samuel Hawley	1 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—t-tz-23—M&T—100 Bks.

D 87332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87332

CERTIFICATE OF DEATH.

REGISTERED NO. 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 W. Franklin St. 18 WARD)

2-FULL NAME Merrick Hunter

(a) RESIDENCE NO. 863 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Susie Hunter

6 DATE OF BIRTH (month, day, and year) about 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Fairfield Farms Dairy

9 BIRTHPLACE (city or town) (State or country) Centreville, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Susie Hunter
(Address) 1118 Division St.

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

May 26, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL 5-28 1924

20 UNDERTAKER John Bowers

ADDRESS 538 Dolphin St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87333

CERTIFICATE OF DEATH.

90 D 87333

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 East Eager St ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert James Tumbleson

(Residence in Baltimore: No. 12 East Eager St St.; 69 yrs., X mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~SINGLE, MARRIED,~~ WIDOWED, ~~OR DIVORCED,~~ (*Write* the word.) widower

6-DATE OF BIRTH, May 3, 1855 (Month) (Day) (Year)

7-AGE, 69 yrs. 0 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Interior Decorator
(b) General nature of industry, business, or establishment in which ~~employed~~ (or employer)..... " " 053

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Charles Henry Tumbleson

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Sarah Donahue

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Elizabeth Tumbleson Fretcher

(Address)... 12 East Eager St.

15-

MAY 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10th 1923, to May 23rd 1924, that I saw h~~im~~er alive on May 23rd 1924, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency with acute Cardiac decompensation.

(Duration)...1...yrs...6...mos...—...ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis Several

(Duration)...yrs...mos...ds.

(Signed) Thomas B. Fotcher M. D.

May 26, 1924. (Address) 1129 N. Calvert St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, May 27, 1924

20-UNDERTAKER Chas. E. Franck ADDRESS 12 Madison St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B. Pat has been acutely ill since May 16th. Was D. John A. Fotcher's father-in-law & was under his direct care. I am sending him a copy of this

D 87334

Spec. [illegible] Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 87334

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1904 W Pratt ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavinia Millers

(a) RESIDENCE. NO. 1904 W Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Spearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary A Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Susan Spearman
(Address) 1904 W Pratt St

MAY 27 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/27/ 1924, to 5/26/ 1924,
that I last saw h[illegible] alive on 5/25/ 1924,
and that death occurred, on the date stated above, at 2 4 m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Heart 2 yrs. mos. ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj F Long, M. D.

5/26/ 1924 (Address) 1100 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	May 28 1924
20 UNDERTAKER	ADDRESS
John J Fields	120 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87335 HEALTH DEPARTMENT—CITY OF BALTIMORE 45 D 87335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 N. Lakewood Ave. ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Murray

(a) RESIDENCE NO. 542 N. Lakewood Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elijah Murray

6 DATE OF BIRTH (month, day, and year) Jan. 19, 1865

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	59	4	5	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Chas. V. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margt. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elijah Murray

(Address) 542 N. Lakewood Ave.

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to May 23, 1924, that I last saw ... alive on May 23, 1924, and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

..... (duration) ... yrs. unknown mos ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Symptomatology

(Signed) Walter A. Klopp, M. D.

5/27, 1924 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and t2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cek Lawn Cemetery	May 27 1924
20 UNDERTAKER	ADDRESS
Wm. C. Black,	927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87336

CERTIFICATE OF DEATH.

D 87336

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John T. Magee

(a) RESIDENCE NO 107 N. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 3 mos. 24 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or WIFE of)~~ Lillie Magee

6 DATE OF BIRTH (month, day, and year) 2/3/57

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler
(b) General nature of industry, business, or establishment in which employed (or employer) Maker
(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John T Magee

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Lillie Magee
(Address) 107 N. Port St.

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

(Signed) J. Wilson Owen, M. D.
(Coroner.)
5/27, 1924 (Address) 508 E Fountain

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 5/28 1924

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87337. CERTIFICATE OF DEATH. 1824 D 87337.

1-PLACE OF DEATH 28 Sessonsville St. 12 REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	✓

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	45 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Phila. Health Dept.
(Address)

Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental

Drowning

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrissey, M. D.
(Coroner.)

May 2 1924 (Address) 7692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL May 26 1924

20 UNDERTAKER [redacted]

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-008

D 87338

CERTIFICATE OF DEATH

D 87338

REGISTERED NO.....

1-PLACE OF DEATH (a) CITY OF BALTIMORE: (NO.) Pier 4 Locust Pt. 25-Muirwood ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME T. Gonzalez Ilf-Huerva.

(a) RESIDENCE (NO.) SS-Muirwood-Pier 4 ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	M T G

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work SS Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mexico.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant .....
(Address) .....

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia

Exhaustion (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo C Blades, M. D.
(Coroner.)

5/27/24, 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 192

20 UNDERTAKER .....

ADDRESS .....

Commissioner Health, MAY 26 1924

THE MORGUE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87339

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 ✓ D 87339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Lexington House ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alex Lee.

(a) RESIDENCE NO Lexington House ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	B	Not Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86 —			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) —
(State or country) —

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14
Informant .....
(Address) .....

15 MAY 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Borden Comp.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Blood, M. D.
(Coroner)

5/24/24 (Address) 1443 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 192

20 UNDERTAKER Commissioner Health,

ADDRESS Rev. Wm. R. WOODALL

MAY 27 1924 THE ASSOCIATED

2 CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87340 ✓

D 87340

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hayne

(a) RESIDENCE NO. Pratt & Albemarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital (Address)

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24 1924

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1923, to 5-24, 1924, that I last saw him alive on 5-24, 1924, and that death occurred, on the date stated above, at 10:50 P m.

The CAUSE OF DEATH* was as follows:

Senile Heterotaxia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inf.

(Signed) Claude A. Dame, M. D.

5-25 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Municipal Hospital

ADDRESS

Spec.—8-24-14—M. & T.—2000 Blks.

D 87341

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-00 D 87341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. Maly Franklin Sq Hosp 19 ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Myer

(Residence in Baltimore: No. Franklin Sq Hospt St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M.	White	—

6-DATE OF BIRTH, 5-22-24, 1 (Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 5 ds. — If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, James Myer

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Marie Hament

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Myer

(Address) 220 W Saratoga St

15-

MAY 27 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 5-24, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5-22 1924, to 5-24 1924, that I saw h~~im~~er alive on 5-24 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature

6 mos

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

May 27, 1924 (Address) 330 N Chas St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Balto Hebrew Cemet	5-27, 1924
20-UNDERTAKER Arl Grinson & Bro	ADDRESS 1127 E Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87342

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87342

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Greene Sts ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Henry Smith

(a) RESIDENCE NO. 1629 E Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Adler.

6 DATE OF BIRTH (month, day, and year) Mar 25 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45.	2.	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 063

(b) General nature of industry, business, or establishment in which employed (or employer) Government Printing

(c) Name of employer Office Wash D C.

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Rawling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known.

14 Informant Mrs Sophia Smith

(Address) 1629 E Lanvale.

15 MAY 27 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 26, 1924, that I last saw h[illegible] alive on May 26, 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Hypertension, Cerebral Arteriosclerosis

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab. findings

(Signed) James T. White, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 5/28/1924

20 UNDERTAKER E J Dunning & Son 1938 E Lafayette a — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87343

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87343

CERTIFICATE OF DEATH.

REGISTERED No. C 31

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 707 N. Caroline St.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lewis Simon

(Residence in Baltimore: No. 707 N. Caroline St.; yrs., 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April (Month) 10 (Day), 1891 (Year)

7-AGE. 33 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Wm Simon

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maggie Ramon

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Boyd Simon (colo)

(Address) 707 N. Caroline

MAY 27 1924

Filed....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
accidentally/stomach tube
on St. Paul about apr 14th 9 P.M.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis T.B. but doubtful

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Collier (Coroner.) M. D.

May 27, 1924 (Address) 506 Fountain Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Lemel Cemetery

DATE OF BURIAL, May 27, 1924

20-UNDERTAKER Mrs. R. E. Elliott

ADDRESS 1225 Eastlandave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87344

CERTIFICATE OF DEATH.

D 87344

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1718 Barclay St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Geo. H. Kurtz

(a) Residence No. 1718 Barclay St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Emma K. Kurtz

6-DATE OF BIRTH (month, day and year) March 11-18

7-AGE, 62 yrs. 2 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)..... 066

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Pa

PARENTS.

10-NAME OF FATHER, Henry Kurtz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Jane Fulton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa

14- (Informant). Emma K. Kurtz

(Address) 1718 Barclay St.

Filed MAY 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 25 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924, to May 25 24

That I last saw him alive on May 25th 24

And that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Chronic Valvular Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. O. Stans, M. D.

May 26 1924 (Address) 1501 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cem. DATE OF BURIAL, May 28, 1924

20-UNDERTAKER, H. A. Weinfeld ADDRESS 919 Eutaw

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12th D 87345

REGISTERED NO.....

1-PLACE OF DEATH Bon Secours Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Payson ST., 70 WARD)

2-FULL NAME Mrs. Annie Rosenthal

(a) RESIDENCE NO. 2037 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Rosenthal

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Fird Bruser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 Eutaw

15 Filed MAY 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 27, 1924,

that I last saw her alive on May 27, 1924,

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis & Cholelithiasis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 27th

Was there an autopsy? No. Removal of Gall Stones

What test confirmed diagnosis? Operation & Clinical

(Signed) H. Hamburger, M. D.

5/27/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 5/27 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

William E. Hause

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87346

CERTIFICATE OF DEATH.

182

D 87346

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harbor Hospital ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME W. E. Hause

(a) RESIDENCE NO 823 S. Hanover St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter 050
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) West Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant David H. Wilkes
(Address) 530 S. Hanover St.

15 Filed MAY 27 1924, 192 ..... RRH.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to Res death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning Accd.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wades, M. D.
(Coroner)

5/27/24 192 (Address) 43 N. Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL May 28 1924

20 UNDERTAKER Michael Doyle — ADDRESS 15 E. Lee St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Janley)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87347.

CERTIFICATE OF DEATH.

161-08 ✓ D 87347.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be stated EXACTLY. PHYSICIAN'S should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Janley

(a) RESIDENCE NO. 214 S. Morris ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 5 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Janley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Mary Janley (Address) 214 S Morris St

15 Filed , 19 RRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25 1924.

17

I HEREBY CERTIFY, That I attended deceased from 5/17, 19 24 to 5/25, 19 24.

that I last saw him alive on 5/25, 19 24

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumatosis

Intestinal upset

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal upset

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	5/27 1924
UNDERTAKER	ADDRESS
H. A. Farley Sons	Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D 87348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 N. Carey ST., 16 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Walter Watts

(a) RESIDENCE NO. 816 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife~~ of Sarah Watts

6 DATE OF BIRTH (month, day, and year) Nov 26- 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont. Know

14 Informant Nora Lewis

(Address) 816 N. Carey St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1923, to May 25, 1924, that I last saw h alive on May 25, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Findings

(Signed) James Brown, M. D.

May 25, 1924 (Address) 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 29 1924
20 UNDERTAKER	ADDRESS 1078 N Eddle
Samuel H Hensley	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... of certificates.

Cor.—1-12-23—M&T—100 Blks.

(Lane)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87349

CERTIFICATE OF DEATH.

74-801 ✓ D 87349

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Pearce st ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Lane -

(a) RESIDENCE NO 914 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Dont Know ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant May Wilson
(Address) 504 Pierce st

15 Filed MAY 27 1924 192 R P W Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) a few hours ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) W K Goodrich, M. D.
(Coroner.)

5-27, 1924 (Address) 117 N Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mechanicsville Va — DATE OF BURIAL 5-28 1924

20 UNDERTAKER David Easton — ADDRESS 916

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87350

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901 ✓ D 87350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE: (No. 504 Walnut ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Roane

(a) RESIDENCE NO. 504 Walnut ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mell	Colord	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City —

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER ~~Unknown~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George E. Edmunds

(Address) 504 Walnut St

15 MAY 27 1924 . 19 RRD Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1924 to May 27, 1924, that I last saw him alive on May 27, 1924, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? XXXX

Did an operation precede death? No Date of XXXX

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-28 1924
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8735I

CERTIFICATE OF DEATH.

101 D 8735I

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Augustus Cole.

(a) RESIDENCE NO. 934 Woodycrest Av. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colrd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Dwight Cole

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Jennie Linell

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Jennie Cole

(Address) 934 Woodycrest Ave

15 Filed ..... 19 ..... Registrar

MAY 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/20/24, 19 ... to 5/26/24, 19 ...

that I last saw h[illegible] alive on 5/26/24, 19 ...

and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Massive Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Winston Jr., M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-28-1924
20 UNDERTAKER David Easter	ADDRESS 916 Pc ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87352

CERTIFICATE OF DEATH.

4 × 101

1-PLACE OF DEATH University Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green Sts., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Hall.

(a) RESIDENCE NO. 110 Bonifas Ave. ST., WARD

(Usual place of abode) Catonsville Md.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) UNK. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer) 071

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harrison Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) University Hosp. Records

15 Filed MAY 27 1924, 19 R C H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26. 19 24

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to May 26. 19 24.

that I last saw her alive on May 26 19 24,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

(1) Pyonephrosis.

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Lobar pneumonia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of May 2 1924

Was there an autopsy? no.

What test confirmed diagnosis? Physical findings

(Signed) John N. Edmonds, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-28 1924

20 UNDERTAKER David Easton

ADDRESS 916 Pe ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87353

CERTIFICATE OF DEATH.

D 87353

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 15 Ward)

Registered No. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo Dorsey

(a) Residence No. 1371 Woodyear st. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of --

6-DATE OF BIRTH (month, day and year) 1908

7-AGE.	If LESS than 1 day,
16 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Truck drivar

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, Zack Dorsey

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Lulu Pinkney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records

(Address) M. T. H.

15- Filed 192 RPH Registrar.

MAY 2 71924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 12 1924 to May 26 1924

that I last saw h. im alive on May 26 1924

and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally M. D

5-27- 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
W. Lawn Cem	5-28, 1924
20-UNDERTAKER,	ADDRESS
Hamil Easton	916 Pa. Ave.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21 – E.B.R.S.—400 Bks.

D 87354 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 87354

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Taylor

(a) Residence No. 650 George St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1899

7-AGE.	If LESS than 1 day.
25 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Edward Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Olivia Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- MAY 27 1924 192 RPH Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 24, 19 24 to May 24 19 24

that I last saw her alive on May 24 19 24

and that death occurred, on the date stated above, at 6.20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lally M. D

5-24 , 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	5-28 19 24
20-UNDERTAKER.	ADDRESS 916
Dan'l Hayden	Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87355 ✓

D 87355

31

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Ferguson

(a) Residence No. 1117 Stricker st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1901

7-AGE.	If LESS than 1 day,
23 yrs. mos. ds.	hrs. nr. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Samuel Ferguson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M. T. H.

15- Filed ..... 192.. Registrar.

MAY 27 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 22, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 19 1924 to May 22 1924

that I last saw h.. im alive on May 22 1924,

and that death occurred, on the date stated above, at 5.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mns. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. G. Kelly, M. D

5-22, 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ..., 19..
Mt Auburn	5-25-24
20-UNDERTAKER, David Easton	ADDRESS 916 Pine

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87356 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 87356

CERTIFICATE OF DEATH.

4 181-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 W Fayette ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David D Marks

(a) RESIDENCE NO 710 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk, Off
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B&O R.R. Co

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER John Y Marks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jr Va.

12 MAIDEN NAME OF MOTHER Eliz A. Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill

14 Informant John D Marks
(Address) 584 Virginia St Toledo Ohio

15 Filed MAY 27 1924 192 Registrar R P W

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(duration) 9 Minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental Suicide

(duration) yrs. mos. ds.

(Signed) H K Loucks, M. D. (Coroner.)

5-27, 192 4 (Address) 111 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Akron Ohio. DATE OF BURIAL May 28 192 4

20 UNDERTAKER Mc Mus. John D Teufel & Son ADDRESS 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87357.

CERTIFICATE OF DEATH.

91-003 ✓ D 87357.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Eastern ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carmen Mastracci

(a) RESIDENCE NO 813 Eastern ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Married

6 DATE OF BIRTH (month, day, and year) Aug 20 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81-			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) labor odd
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rose Mastracci
(Address) 813 Eastern Ave

Filed MAY 27 1924, 192 R. P. H. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Clinton Bodell, M. D.
(Coroner)

5/27/24 192 (Address) 142 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents	May 28 192 4
20 UNDERTAKER	ADDRESS
Martin W C Dyer	372 Aisquith

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87358

CERTIFICATE OF DEATH.

171

D 87358

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Fobbe

(a) RESIDENCE NO. (721) 721 S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Probably60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) John H. Wagner 221 S. Caroline St

15 Filed . 192 R P A Registrar

MAY 27 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-hemorrhage-cut wrists with razor-suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. J. Waller, M. D. (Coroner.)

May 27/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Vincents	May 28 1924
20 UNDERTAKER Richard F. Manley	ADDRESS 1108 Guilford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87359 X 47 D 87359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A. Kelly Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Katherine Carroll.

(a) RESIDENCE No. 323 York Ave., ST., WARD Towanda, Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not married.

6 DATE OF BIRTH (month, day, and year) [illegible] 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No occupation.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bradley Co. (State or country) Pa

PARENTS

10 NAME OF FATHER Mr. John Carroll.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. J. F. Sara. (Sister)
(Address) Jacksonville, Fla.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1921, to May 27, 1924, that I last saw h[illegible] alive on May 27, 1924, and that death occurred, on the date stated above, at 1 40 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast with metastases to spine.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-rays

(Signed) Robert E. Preece, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Towanda Penna.	May 27 1924

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

M 2 7 1924

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87360 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87360

CERTIFICATE OF DEATH. X-19

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 11 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Samuel R. Ransom

(a) RESIDENCE NO. Smyrna Del. ST., WARD Smyrna Del.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Smyrna Kent Co Delaware

PARENTS

10 NAME OF FATHER William A Ransom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Smyrna Kent Co Delaware

12 MAIDEN NAME OF MOTHER Sarah E Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Smyrna Kent Co Delaware

14 Informant William Ransom Jr (Address) Smyrna Del

15 Filed . 19 Registrar

MAY 27 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-24

17 I HEREBY CERTIFY, That I attended deceased from 5-13 , 1924, to 5-27 , 1924, that I last saw him alive on 5-27 , 1924, and that death occurred, on the date stated above, at 12 45 0 m.

The CAUSE OF DEATH* was as follows:

Neoplasm of Spine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Stock following Operation 5-26 yrs. 24 mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? yes Date of 5-26-24

Was there an autopsy? No

What test confirmed diagnosis? Lab. & clinical

(Signed) Jno A Young Jr M. D.

. 19 (Address) MD Smyrna Del.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington Del DATE OF BURIAL May 27 1924

20 UNDERTAKER H. Vander & Sons ADDRESS 1710 Fleet St.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of Info... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... show ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8736F

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 8736F

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1931 Madison ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Behr Hirschmann

(a) Residence No. 1931 Madison ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced. (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elma Hirschmann

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 80 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of Industry, business, or establishment in which employed (or employer). Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Aaron Hirschmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15- MAY 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from ? 1921 to May 27 1924

that I last saw him alive on May 27 1924

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris Arteriosclerosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual signs of myocarditis

(Signed) Chas Cluse M. D

, 19 (Address) 1701 Madison ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Reisterstown	5/30 1924
20-UNDERTAKER.	ADDRESS
Jack Lewis	1439 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87362

CERTIFICATE OF DEATH.

5/ D 87362

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ray London

(a) RESIDENCE NO. 1622 Eutaw Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept. 12/1916

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... school boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel London

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Cohen

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Samuel London
(Address) 1622 Eutaw Place

MAY 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis-
Myocardial Failure

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Mallen, M. D.
(Coroner.)

May 27 192 4 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 5/28 1924

20 UNDERTAKER Jack Levin

ADDRESS 1439 E. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87363

CERTIFICATE OF DEATH.

128

D 87363 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Penna Ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Carter

(a) RESIDENCE NO. 1223 Penna Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Centenarian

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) va

PARENTS

10 NAME OF FATHER Logan Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) va

12 MAIDEN NAME OF MOTHER Mary Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) va

14 Informant Mary Gray
(Address) 1223 Penna ave

15 MAY 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to May 25, 1924.
that I last saw h[illegible] alive on May 24, 1924.
and that death occurred, on the date stated above, at 7a m.
The CAUSE OF DEATH* was as follows:

Acute Uremea 040
(duration) 2 yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Acute Parenchymatous
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? On Steam Ship
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) B. H. Hatcher, M. D.
5/25, 1924 (Address) 1225 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 28, 1924
20 UNDERTAKER	ADDRESS
Joseph A Farrell	2319 Division

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

175 D 87364

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1338 W. Carey ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome Mahone

(a) RESIDENCE NO. 509 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Josiah Marine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Janie Asher

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant (Address) Mrs Thomas 509 N. Gilmor St

15 Filed MAY 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1924, to May 27, 1924, that I last saw him alive on May 27, 1924, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Gastritis (Toxic)

(duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? 509 N. Gilmor St

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M Hayer, M. D.

5/27/1924 (Address) 513 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL May 28 1924

20 UNDERTAKER John H. Toodon

ADDRESS 942 Lexington St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87365

D 87365

CERTIFICATE OF DEATH.

5/161-00?

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 5th St Fairfield ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonora R. Kraus

(a) RESIDENCE No. 5th St Fairfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/26/24.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Sam C. Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Hooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sam Hess (Address) 5th St Fairfield

15 Filed MAY 28 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26—1924

17 I HEREBY CERTIFY, That I attended deceased from 5/26, 1924, to 5/26—, 1924.

that I last saw h— alive on 5/26— 1924

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH was as follows:

death following Instrumental Delivery

(duration) yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Org. Tumor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A. K. Dewey, M. D.

, 19 (Address) 1310 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Magothy A.A. Co. Md

DATE OF BURIAL 5-28 1924

20 UNDERTAKER John H. Toadvine

ADDRESS 142 W. Hill St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87366

CERTIFICATE OF DEATH.

D 87366

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St. & Rutland Ave ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Banks

(a) RESIDENCE NO. 702 No Bradford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Banks

6 DATE OF BIRTH (month, day, and year) March 28, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Columbia

(c) Name of employer Graphone Co.

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER William Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rachel Bilkenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Amelia Banks

(Address) 702 N. Bradford St

15 MAY 28 1924 ROBERT J. KRAUTER, KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/23, 1924, to 5/25, 1924, that I last saw him alive on 5/25, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) General carcinomatosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/24/24

Was there an autopsy? yes

What test confirmed diagnosis? Histology

(Signed) H Adler Feinberg M. D.

5/26, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Poplar Harford Co. Md.	May 28 1924
20 UNDERTAKER	ADDRESS
H. Lander Sons	1710 Eutaw St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87367.

CERTIFICATE OF DEATH.

+41 D 87367

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georges P. Romieike

(a) RESIDENCE NO. ..... New York ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 27 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Mary Romieike

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... President

(b) General nature of industry, business, or establishment in which employed (or employer) Incorporation Co's

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Henry Romieke

11 BIRTHPLACE OF FATHER (city or town) Riga (State or country) Russia

12 MAIDEN NAME OF MOTHER Eugenie Dayez

13 BIRTHPLACE OF MOTHER (city or town) Israel (State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 MAY 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30th, 1924, to May 27th, 1924, that I last saw him alive on May 27th, 1924, and that death occurred, on the date stated above, at 6.00 p. m.

The CAUSE OF DEATH* was as follows:

Streptococcus viridans Endocarditis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) ..... yrs. ..... mos. 14 hours.

18 Where was disease contracted if not at place of death? 26 Fifth Ave New York City

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy and Cultures

(Signed) Winfield W. Scott, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and (Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City — DATE OF BURIAL May 28, 24

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Hall.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87368

D 87368

CERTIFICATE OF DEATH. X 101-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Memorial Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Hall

(a) RESIDENCE No. 1118 N. Fraiten St ST., WARD Georgia

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Abram Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Frances Stubs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Wm. H. Hall

(Address) 1223 Boyd ST

Filed MAY 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 25, 1924, that I last saw h alive on May 25, 1924, and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pneumococcus Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John M. Edmunds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MD Zion Cmty	5-29-1924
20 UNDERTAKER Mrs Helena A. Holland	ADDRESS 1631 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87369

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 ✓ D 87369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren French

(a) RESIDENCE NO. 1423 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) unknown Apr 11, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	2			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Herbert French

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle Bowie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Myrtle Bowie French
(Address) 1423 Ashland Ave

15 Filed MAY 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulm. & Meningeal Tuberculosis

(Autopsy at Hopkins Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Weller, M. D.
(Coroner.)

May 28/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery May 28th	1924
20 UNDERTAKER	ADDRESS
Milton Davis	316 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87370

101-001 ✓ D 87370

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 W. Henrietta St. ST., 23 WARD)

2-FULL NAME Rose Sanders. (C).

(a) RESIDENCE NO 237 W. Henrietta St. ST., ... WARD .....
(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married.

5a If married, ~~widowed or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Hugh Sanders. (C).

6 DATE OF BIRTH (month, day, and year) March 18, 1906.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) A. A. Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph White. (C)

11 BIRTHPLACE OF FATHER (city or town) A. A. Co Md.
(State or country)

12 MAIDEN NAME OF MOTHER Alverta Green. (C).

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co. Md.
(State or country)

14 Informant Hugh Sanders. (C) (husband).
(Address) 237 W. Henrietta St.

15 MAY 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

May 26, 1924. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn ct — DATE OF BURIAL May 28 1924

20 UNDERTAKER L. E. Brown & Son — ADDRESS 1086 W. Mond[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8737E

CERTIFICATE OF DEATH.

188-003

D 8737E

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST. 23 WARD)

2-FULL NAME Mabel Howard (C).

(a) RESIDENCE No 1131 S. Howard Street. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) March 26, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	3	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Howard. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Annie Simms (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Eliza Simms (C)(grandmother)
(Address) 1131 S. Sharp Street.

15 Filed MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Issuer

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck by automobile truck while crossing the street.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)
May 27, 1924. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Cross St. & Peach Alley. May 26th, 1924.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	May 29 1924
20 UNDERTAKER	**ADDRESS**
S. E. Brown & Son	1084 Mund-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87372

CERTIFICATE OF DEATH.

90 D 87372

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Lamont Av ST., 9 WARD)

2-FULL NAME Mrs. Mattie E. Bair

(a) RESIDENCE No. 1513 La Mont Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Bair

6 DATE OF BIRTH (month, day, and year): 5/29/1849

7 AGE — Years: 74 — Months: — Days: — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm. Biggins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Katherine Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Mrs Helen Olsen
(Address) 1513 Lamont Ave

15 Filed MAY 28 1924, 19.... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May-27 1924

17 I HEREBY CERTIFY, That I attended deceased from May-20, 1924, to May-27, 1924, that I last saw her alive on May 27, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Oedema of Lungs -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) E. Gill Hall M. D.

May 27 1924 (Address) 1631 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: 5/29/1924

UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87373

CERTIFICATE OF DEATH.

74 D 87373

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1379 N Carey St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Chas. Watkins

(a) Residence No. 1379 N Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year)

7-AGE. 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Howard Co Md

PARENTS.

10-NAME OF FATHER, Charles Watkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Carter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Carter

14- (Informant) Mrs Holmes

(Address) 1379 N Carey St.

MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 24/24

17- I HEREBY CERTIFY, That I attended deceased from May 12 1924 to May 24 1924

that I last saw h[illegible] alive on May 23 1924

and that death occurred, on the date stated above, at 1130 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Senile debility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) H. M. Earle M. D.

5/27, 1924 (Address) 1001 Wilkens Ave

*State the **Disease Causing Death**, or In deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mission Par — DATE OF BURIAL. May 28 1924

20-UNDERTAKER. Samuel Hawley — ADDRESS 678 N Biddle St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Burget

HEALTH DEPARTMENT—CITY OF BALTIMORE 01 87374

D 87374

CERTIFICATE OF DEATH.

101-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3304 Mynster Place. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin A. Burget

(a) RESIDENCE No. 3304 Mynster Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Benjamin A. Burget

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Emma Potts.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Brooklyn. a.h. Co., Md.

14 Informant Benj. A. Burget
(Address) 3304 Mynster Place

15 Filed MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from May 26- , 1924, to May 27 , 1924.

that I last saw him alive on May 26, , 1924,

and that death occurred, on the date stated above, at 7:50 a. m.

The CAUSE OF DEATH* was as follows:

Bi Lateral Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? none.

(Signed) Allen C Beetham, M. D.

5-27 1924 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 5/30 1924

20 UNDERTAKER William Cook

ADDRESS 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87375

D 87375

CERTIFICATE OF DEATH.

6 178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N. Hare ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Lammlein

(a) RESIDENCE NO 143 N. Hare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Lammlein

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	About 57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): B &O R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Minnie Lammlein
(Address): 331 S. Payson

15 Filed MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192: May 26-24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure-Pulm. Oedema due to Smoke Asphyxia, residence afire on May 24/24

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Paul (Coroner.), M. D.

May 26/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 28, 192[illegible]
20 UNDERTAKER	ADDRESS
Wm. Cook	[illegible]

D 87376

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D 87376

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 400 N. Fulton Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Sophia Chalk.

(Residence in Baltimore: No. Home for the aged of the M.E Church St.; 80 yrs. ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow

6-DATE OF BIRTH: Mch 20, 1833. (Month) (Day) (Year)

7-AGE: 91 yrs. 2 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: None. 420
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Saxony Germany. Came to U.S about 87yrs

PARENTS

10-NAME OF FATHER: Geo. C Beck.

11-BIRTHPLACE OF FATHER (State or country): Germany.

12-MAIDEN NAME OF MOTHER: Eva. Colditz.

13-BIRTHPLACE OF MOTHER (State or country): Leipsic Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Etta Cuddy.

(Address) 400 N. Fulton Ave.

15 MAY 28 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: May 27, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1923 to May 27 1924.
that I saw her alive on May 27, 1924.
and that death occurred, on the date stated above, at 2.30 p. m.
The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 2 yrs. ✓ mos. ✓ ds

Contributory (SECONDARY) Senile Debility

(Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) George C Shannon M. D.

May 27, 1924 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cem

DATE OF BURIAL: May 29, 1924

20-UNDERTAKER: George J. Smith

ADDRESS 1532 Pollitt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

D 87377. HEALTH DEPARTMENT—CITY OF BALTIMORE D 87377.

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH Colonial Hospital

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1122 N. Mount ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse Hammond

(a) RESIDENCE NO. 1314 N. Parish ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Hammond (wife)

6 DATE OF BIRTH (month, day, and year) Nov 24-89

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	34	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Dave Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Sally Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Jesse Hammond

(Address) 1314 N. Parish St

15 MAY 28 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1924

17 I HEREBY CERTIFY, That I attended deceased from 3-31 , 1924 , to May - 25 , 1924 ,

that I last saw him alive on May 24 , 1924 ,

and that death occurred, on the date stated above, at 3 08 a.m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix

Generalized Peritonitis

6 weeks (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

2 wks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at work

Did an operation precede death? Yes Date of 3-31-24

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. A. Sussman M. D.

5-25 1924 (Address) 1122 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Ber. A. C. DATE OF BURIAL May 28 1924

20 UNDERTAKER Wm. H. Sheeter ADDRESS 1400 Walbrook

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Dembeck

HEALTH DEPARTMENT—CITY OF BALTIMORE

172D 87378

CERTIFICATE OF DEATH.

52 D 87378

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora Dimbeck

(a) RESIDENCE NO. 622 S. Glover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 13-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	10	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Dimbeck

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 26, 1924, that I last saw her alive on May 26, 1924, and that death occurred, on the date stated above, at 6-40 P. m.

The CAUSE OF DEATH* was as follows:

~~Rheumatic Heart Disease~~
Myocardial Insufficiency

(duration) yrs. 10 mos ..... ds.

CONTRIBUTORY (Secondary) Rheumatic Heart Disease

(duration) yrs. 20 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R. Bugg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	May 30 1924.
20 UNDERTAKER	ADDRESS
W. J. Sadowski	905 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87379

CERTIFICATE OF DEATH.

49 D 87379

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 S Chapel ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Czosnowski

(Residence in Baltimore: No. 616 S Chapel St.; 45 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~SINGLE, MARRIED, WIDOWED OR DIVORCED?~~ (Write the word.) Widow

6-DATE OF BIRTH, Nov. 2, 1865.
(Month) (Day) (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, —?— Trbulski

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Antmour

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..~~Daughter~~ Vincent Czosnowski

(Address) 616 S. Chapel St.

MAY 28 1924

Filed....., 191.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ~~Oct.~~ May 26 1924, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1924, to May 26 1924, that I saw h alive on May 26 1924, and that death occurred, on the date stated above, at 7.25 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration)...yrs...mos...1...ds.

CONTRIBUTORY (Secondary) Sarcoma of Leg

(Duration)...yrs...6...mos...ds.

(Signed) P.D. Keller M. D.

May 26, 1924 (Address) 10 N. Luzerne

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus Cem.

DATE OF BURIAL, May 30th, 1924

20-UNDERTAKER M. J. Sadowski

ADDRESS 705 S. Ann St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87380

100-0012

CERTIFICATE OF DEATH.

D 87380

Registered No.....

1-PLACE OF DEATH Municipal Hospital

City of BALTIMORE: (No. Bay View Hospital, 8 ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Proctor

(a) Residence No. 1221 N. Dallas St., ...Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	Black.	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1874.

7-AGE.	If LESS than 1 day.
50 yrs. ... mos. ... ds.	... hrs. or ... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Harriet Dickerson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) ... (Address) Hospital Records

15- Filed MAY 28 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 24-24

17- I HEREBY CERTIFY, That I attended deceased from April 5 ..., 1924, to May 24 ..., 1924, that I last saw h[illegible] alive on May 24 ..., 1924, and that death occurred, on the date stated above, at 4 30 P. M.

The CAUSE OF DEATH* was as follows:

Fibrous Myocarditis

Infected Varicose Ulcers of both Legs -

(Duration) 6 yrs. ... mos. ... ds

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(Duration) ... yrs. ... mos. 2 ds

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Facts

(Signed) H. P. Chaney M. D., M. D.

, 19 (Address) Municipal Hall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel cemetery	may 28 1924
20-UNDERTAKER.	ADDRESS
Edward Bryor	631 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Zeitlan

D 87381 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Zeitlan

(a) RESIDENCE NO. 1103 Rutland Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Morris Zeitlan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Lottie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Morris Zeitlan

(Address) 1103 Rutland ave

15 Filed MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-27 1924

17

I HEREBY CERTIFY, That I attended deceased from January 16, 1924, to May 27, 1924

that I last saw him alive on May 27, 1924

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction, chronic

Imperforate anus.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 1-16-24, 2-4-24, 3-4-24, 5-16-24

Was there an autopsy? No

What test confirmed diagnosis? Operations.

(Signed) Henry W. P. Wilson Jr M. D. M. D.

5/28 1924 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 5/30 1924

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto st

Spec.—1-10-21—M&T—1500 Bks. C. 64104

D 87382 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-00 D 87382

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Grunner.

(a) RESIDENCE NO. 102 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl 22 1924.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
X	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Charles J Grunner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Corrado

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Josephine Grunner (Address) 745 W. Lexington St.

MAY 28 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/2, 1924, to 5/25, 1924, that I last saw him alive on 5/25, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumatelectasis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Upset.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) R. Peters John M. Edmunds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/ CREMATION OR REMOVAL R. Peters — DATE OF BURIAL 5/28 1924

20 UNDERTAKER J. J. Valley Sons — ADDRESS 1318 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87383

CERTIFICATE OF DEATH.

74-001 V D 87383

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 613 W. Hamburg St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Frank Clarke

(a) Residence No. 613 W. Hamburg St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-~~Single~~ Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Carrie Clarke

6-DATE OF BIRTH (month, day and year): March 27 1864

7-AGE: 60 yrs. 2 mos. 2 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Attorney Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: L. B. Sexton

9-BIRTHPLACE (city or town) (State or Country): Philadelphia Pa

PARENTS.

10-NAME OF FATHER: Pierson Clarke

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Philadelphia Pa

14-(Informant): Mrs Carrie Clarke

(Address): 613 W. Hamburg St

15-Filed MAY 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 26 1924

17- I HEREBY CERTIFY, That I attended deceased from May 24 1924 to May 26 1924

that I last saw h~~im~~ alive on May 24 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wiley Hoag M. D

May 26. 1924 (Address) 729 Park Blvd.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	May 28. 1924
20-UNDERTAKER.	ADDRESS
Jos Jeerdens & Son	217 S. Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87384

CERTIFICATE OF DEATH.

90 D 87384

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1- Chancery Square St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Mary Williamson

(a) Residence No. 1- Chancery Square St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dwight Williamson

6-DATE OF BIRTH (month, day and year) Oct 17. 1862

7-AGE. 61 yrs. 7 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Indiana

PARENTS.

10-NAME OF FATHER Paul P. Hereth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER Sarah Jooler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Mr Dwight W. Williamson

(Address) 1- Chancery Square

15- FILED MAY 28 1924 ROBT. R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26. 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 8, 19 24 to May 26, 19 24

that I last saw h. alive on May 25 19 24

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis (Mitral regurgitation)

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute cardiac decompensation

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) George M. Little M. D.

May 26 1924 (Address) 2435 Mary Land Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, May 29 1924

20-UNDERTAKER, Jos Joerdens & Son ADDRESS 2173 Pa Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87385

CERTIFICATE OF DEATH.

155 D 87385

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Eutaw Place ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian M. Matthews

(a) RESIDENCE NO. 1516 Eutaw Place ST., WARD Oakmoke Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank B. Matthews

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Oakmoke Md
(State or country)

PARENTS

10 NAME OF FATHER Sidney Townson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Carrie C. Todden

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Frank B. Matthews
(Address) 1516 Eutaw Place

15 MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to May 28, 1924, that I last saw h[er] alive on May 28, 1924, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Mastoiditis Bilateral
Septicemia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? c Date of 25 Paracentesis

Was there an autopsy? no 7 Ear drum

What test confirmed diagnosis? Blood Count Temp Pulse

(Signed) Joseph [illegible] Elmer, M. D.

, 19 (Address) 1516 W Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakemoke Md — DATE OF BURIAL May 29 1924

20 UNDERTAKER J. Ahrens & Co — ADDRESS 1611 Mad Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Rappeport

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87386 — 179 — D 87386

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2334 Reisterstown ..... St., 15 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Rappeport

(a) Residence No. 2334 Reisterstown Rd St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Freida Rappeport

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE: 69 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of Industry, business, or establishment in which employed (or employer): Merchant
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-(Informant): Jack Levis
(Address): 1439 E Balto St

15- MAY 28 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 27 1924

17- I HEREBY CERTIFY, That I attended deceased from March 9, 1922 to May 27, 1924 that I last saw him alive on May 27, 1924 and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy - followed by Uraemia

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary): Chronic Nephritis, Hypertension

(Duration) 5 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? — Place of Death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual Laboratory Test.

(Signed) Joseph Williams Kelly M. D.

19 (Address) 910 Brooks Lane

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Bikur Cholem Cem — DATE OF BURIAL: 5/28 1924

20-UNDERTAKER: Jack Levis — ADDRESS: 1439 E Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87387

CERTIFICATE OF DEATH.

D 87387

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1709 Barclay St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma McCormick

(a) Residence No. 1709 Barclay St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred About 63 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Do not know

7-AGE. About 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Thomas McCormick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Do not know

12-MAIDEN NAME OF MOTHER, Catherine ------

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Do not know

14- Mrs. C. C. Greene (Informant)

(Address) 1709 Barclay St.

15- MAY 28 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26 1924

17- I HEREBY CERTIFY, That I attended deceased from October, 1923 to May 26th, 1924 that I last saw her alive on May 26th, 1924 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Right Mammary) of Breast

Metastasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Dont know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) J. B. Schwatka, M. D

19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Druid Ridge Cemetery	5/28 19 24

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 87388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 ✓ D 87388

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Battenfeld

(a) Residence No. 3805 Mt. Pleasant Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 67 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Maryland.

PARENTS.

10-NAME OF FATHER Louis Battenfeld

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anne Battenfeld

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Mary Ender

(Address) 3815 Mount Pleasant

15- MAY 28 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/27/24.

17. I HEREBY CERTIFY, That I attended deceased from April 24 1924 to May 27 1924, that I last saw him alive on May 27 1924 and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Bronchial Cleft

General Metastasis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D.

. 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cem

DATE OF BURIAL. May 29. 1924

20-UNDERTAKER. John Keller et

ADDRESS 2008 Orleans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

17968 87389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 87389

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL 24 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Tilley

(a) RESIDENCE NO. 1532 Latrobe Pk Towson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER David Tilley

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Lewis

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 FILED MAY 28 1924 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to May 27, 1924, that I last saw him alive on May 27, 1924 and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/23/24 - 5/24/24

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. F. Kopp M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill 6mm.

DATE OF BURIAL 5/29 1924

20 UNDERTAKER L. Few Mc Cully

ADDRESS 130 E. Fort

MAY 28 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. If information is not known, so report. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 87390

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87390

91-000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1729 Bank St. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lukaszewicz

(a) RESIDENCE. No. 1729 Bank St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Lukaszewicz

6 DATE OF BIRTH (month, day, and year) Mar. 12, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 07

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph Bronski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mr. Andrew Lukaszewicz

(Address) 1729 Bank St.

15 Filed MAY 28 1924 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 27, 1924 that I last saw h.d alive on May 26, 1924, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atheromatosis

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Chas. S. Nerstodt. M. D.

19 (Address) 1730 Linden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 30 1924.

20 UNDERTAKER John McAleer ADDRESS 1803 Bank St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 8739I

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8739I

CERTIFICATE OF DEATH.

X 32

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Louis Lukart

(a) RESIDENCE NO. Pickens West Va ST., WARD Pickens W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~WIFE of~~) Bonnie E Lukart

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gas

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Amelia Matthys

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 Robert P. Harrison, Registrar

MAY 28 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 27, 1924, that I last saw h[illegible] alive on May 27, 1924, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Meningitis - tuberculous

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Tuberculosis kidney

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of May 24-24

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological

(Signed) Warfield M Frost M. D.

, 19 (Address) J H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pickens West Va	May 28, 1924
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87392

D 87392

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Cleveland ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Houck

(a) RESIDENCE. No. 1132 Cleveland ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John W. Houck

6 DATE OF BIRTH (month, day, and year) Sept. 29, 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick
(State or country) Maryland

PARENTS

10 NAME OF FATHER Mr. Phoebus

11 BIRTHPLACE OF FATHER (city or town) Frederick
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Crove

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Maryland

14 Informant Mrs. Margaret Yeagle
(Address) 1112 Cleveland Street

15 Filed MAY 28 1924, 19.. Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923 to May 28, 1924, that I last saw h[illegible] alive on May 27, 1924, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Schwartzbach M.D.

5-26 19 (Address) 1126 W. Cross Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Olive Cem. Frederick Md. — DATE OF BURIAL May. 30" 24 19

20 UNDERTAKER Chas B. Cook — ADDRESS 1013 N. Calvert St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Blks.

D 87393 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 87393

CERTIFICATE OF DEATH.

X 73

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma Shipley

(a) Residence No. Ellicott City Md St., Ward Ellicott City, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE~~: Ed Shipley

6-DATE OF BIRTH (month, day and year): Oct 29 1870

7-AGE: 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Frederick Md.

12-MAIDEN NAME OF MOTHER: Mary Saint Pierre

13-BIRTHPLACE OF MOTHER (city or town) (State or Country):

14- (Informant): Ed Shipley
(Address): Ellicott City Md

15- Filed 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 27-24

17- I HEREBY CERTIFY, That I attended deceased from May 16- 1924 to May 27 1924

that I last saw h.. alive on May 27 1924

and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Progressive Anterior Poliovencephalotis

(Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary): Terminal Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Finding

(Signed) L. Goldman M. D

19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or if deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, REMOVAL: St Johns Cem — DATE OF BURIAL: May 31 1924

20-UNDERTAKER: S. Lon Ty Shaw — ADDRESS: Ellicott City Md

Y 28 1924 Burial Permit Clerk.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87394

D 87394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1363 N. Carey ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Smothers

(Residence in Baltimore: No. 1363 N. Carey St.; 55 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	Colored	widowed

6-DATE OF BIRTH, Aug 24, 1869. (Month) (Day) (Year)

7-AGE, 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country), Calvert Co Md.

PARENTS.

10-NAME OF FATHER, William Randall

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leopold Smothers

(Address) Prestman St.

15- May 28 1924

Robert B. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 12 1924, to May 26 1924, that I saw him alive on May 26 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Bon Robertson M. D.

May 26, 1924 (Address) 2134 E. Pratt

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, May 29, 1924

20-UNDERTAKER Mrs Jas. W. Dennis per T. E. Kelson.

ADDRESS 1303 Prestman St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Permission to extend day of burial

D 87395

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87395

May 29, 1924.

Frederick S. Trumpel, Asst. Cor.

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 14 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Leland Spence Jr.

(a) RESIDENCE NO. 1528 John ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5, 1918

7 AGE — Years: 5 — Months: 11 — Days: 22 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto., Md

PARENTS

10 NAME OF FATHER George L Spence

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co, Md

12 MAIDEN NAME OF MOTHER Rose Bonitzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilmington, Del

14 Informant: Geo. L. Spence

(Address) 1526 John St.

15 MAY 29 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27 1924.

17 I HEREBY CERTIFY, That I attended deceased from 5/26/ 1924 to 5/27 1924

that I last saw him alive on 5/27/ 1924

and that death occurred, on the date stated above, at 8.05 A.m.

The CAUSE OF DEATH* was as follows:

Hydrophobia

or acute fulminating meningitis ?

Uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bite of rabid dog.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? on street near home

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Inspection.

(Signed) Wm. S. Love M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: May 29 1924

20 UNDERTAKER: Henry W. Means & Son — ADDRESS: 805 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87396

CERTIFICATE OF DEATH.

100-001

D 87396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1040-Ridgely ST. 18 WARD)

2-FULL NAME Vera Elizabeth Marshall

(a) RESIDENCE NO. 1040 Ridgely ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/16/24

7 AGE — Years: — Months: 4 — Days: 15 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ...

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Victoria Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Victoria Wilson
1040 Ridgely Balto md

MAY 2 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/16, 1924, to 5/27, 1924, that I last saw h[illegible] alive on 5/27, 1924, and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. E. Jackson M. D.

1924 (Address) 8 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MtA Cemetery

DATE OF BURIAL: 5-29 1924

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87397

CERTIFICATE OF DEATH.

91-002 D 87397

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 E. 31st ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Seth A. Marchant

(a) RESIDENCE No. 1934 E. 31st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Marchant

6 DATE OF BIRTH (month, day, and year) Oct. 17-1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Alef. Marchant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Minter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Lillian Lowell

(Address) 1934 E. 31st St.

15 Filed MAY 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to May 26 1924

that I last saw him alive on May 25 1924

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Thrombosis 2 yrs. mos ds.

(duration)

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Graham M. D.

May 27 1924 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL May 29 1924

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87398

CERTIFICATE OF DEATH.

12D 87398

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2529 McCulloh ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jones

(a) RESIDENCE. No. 2529 McCulloh ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Jones

6 DATE OF BIRTH (month, day, and year) Sept 29 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter & Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER George Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Md

12 MAIDEN NAME OF MOTHER Elizabeth Blank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

14 Informant James Jones (Address) 2529 McCulloh St

15 Filed MAY 29 1924 19... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to May 27, 1924, that I last saw him alive on May 27, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Age. Arterio Sclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 660 Pulaski St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

May 29, 1924 (Address) 1209 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Federal Hill	5/31 19...
20 UNDERTAKER	ADDRESS
Theo White	1131 W Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87399

CERTIFICATE OF DEATH.

94 001

D 87399

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 Enson St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Geisler

(a) Residence No. 1313 Enson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? Apl yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If ~~married~~, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Margaret Geisler

6-DATE OF BIRTH (month, day and year) Sept. 12 1855

7-AGE. 68 yrs. 8 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer) Ob

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto (State or Country)..... Md.

PARENTS.

10-NAME OF FATHER, Andrew Geisler

11-BIRTHPLACE OF FATHER (city or town)..... Germany (State or Country).

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... Not Known (State or Country).

14- (Informant) Mrs. Margaret Geisler

(Address) 1313 Enson St

15- MAY 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27 1924

17- I HEREBY CERTIFY, That I attended deceased from May 21 1924 to May 27 1924

that I last saw h. ~~in~~alive on May 27 1924

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal

(Signed) J. W. Nurse, M. D.

May 28 1924 (Address) 1228 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	May 30, 1924
20-UNDERTAKER.	**ADDRESS**
Henry Horde Son	1301 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87400

CERTIFICATE OF DEATH.

D 87400

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Adams St (Walpert & Co) ST., 9 WARD)

2-FULL NAME Joseph A Bormuth

(a) RESIDENCE NO. 7 Adams St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine G. Bormuth

6 DATE OF BIRTH (month, day, and year) Mar 1/1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer (Stationary)
(b) General nature of industry, business, or establishment in which employed (or employer) Walpert & Co
(c) Name of employer Adams St

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Probably Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Probably Germany

14 Informant Catherine G Bormuth
(Address) 7 Adams St

15 Filed MAY 29 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial & Valvular Insuffiemency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S Walter (Coroner.), M. D.

May 28 24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 31 1924
20 UNDERTAKER Henry Hoech Son	ADDRESS 1301 E Eager St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87401

CERTIFICATE OF DEATH.

129 D 87401

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 821 Hillow St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas R. Spicer

(a) Residence No. 821 Hillow St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Sing'l

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 2nd Nov

7-AGE. 84 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Silversmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Pa

PARENTS

10-NAME OF FATHER. Thomas Spicer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Pa.

12-MAIDEN NAME OF MOTHER. Rosanna McClure

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11- (Informant) Mrs Catherine Klootzet

(Address) 821 Hillow St

13- MAY 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-28-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1923 to May 24 1924

that I last saw h.. alive on May 24 1924

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical.

(Signed) A. J. Hamblen M. D

5/28, 1924 (Address) 733 Arsenal St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery

DATE OF BURIAL. May 31 1924

20-UNDERTAKER. Henry Hock Son

ADDRESS 1301 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Elijah Bowen.

D 87402 HEALTH DEPARTMENT—CITY OF BALTIMORE

111-901 D 87402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3416 Cedar ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elijah Bowen

(a) Residence No. 3505 Cedar ave St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 24-1882

7-AGE 42 yrs. 3 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Roland Dairy

(c) Name of employer Dairy

9-BIRTHPLACE (city or town) (State or Country), MD

PARENTS.

10-NAME OF FATHER. Elijah Bowen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), MD

12-MAIDEN NAME OF MOTHER. Martha James

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), MD

14- (Informant) John W. Bowen

(Address) 3416 Cedar Ave

15- MAY 29 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27/24

17- I HEREBY CERTIFY, That I attended deceased from May 22, 1924 to May 27, 1924

that I last saw h... alive on May 26, 1924

and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Gastric Haemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) O. F. Coughlin M. D.

5-27 1924 (Address) 3701 Roland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Marys Hampden DATE OF BURIAL. May 29 1924

20-UNDERTAKER. CHENOWETH & SON ADDRESS 3617 CHESTNUT AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D87403. HEALTH DEPARTMENT—CITY OF BALTIMORE D87403.

CERTIFICATE OF DEATH. 492

1-PLACE OF DEATH

City of BALTIMORE: (No. 5416 Park Heights Ave St., 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pattie M. Haines

(a) Residence No. 5416 Park Heights Ave St., ... Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) May 26 1873

7-AGE, 51 yrs. 0 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Dressmaking

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, James A Haines

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary E. Smallwood

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Guy B Haines

(Address) 5416 Pk Hgts Ave

Filed MAY 29 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May. 28 1924

17- I HEREBY CERTIFY, That I attended deceased from May 14 1924 to May 27 1924

that I last saw h[illegible] alive on May 27 1924

and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

a Carcinoma of Larynx

.....(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

.....(Duration)..... yrs..... mos..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) Owen Dr. Kader M. D.

5/29, 1924 (Address) 300 S N. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, St. Mark's Highland Md | DATE OF BURIAL, 5-30 19.24

20-UNDERTAKER, E & B Harle | ADDRESS 115 E West St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.–400 Bks.

D 87404

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87404

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2116 S. Charles St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel R. Grove

(a) Residence No. 2116 S. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of David R Grove

6-DATE OF BIRTH (month, day and year) May 21-1842

7-AGE. 82 yrs. mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. William High

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto md

12-MAIDEN NAME OF MOTHER. Rachel Gardell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Mrs Agar

(Address) 2116 S. Charles St

15- MAY 29 1924

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-27-24

17- I HEREBY CERTIFY, That I attended deceased from May 1 19 24 to May 27 19 24

that I last saw h alive on May 27 19.....

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D

May 28. 19 24 (Address) 1644 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem — DATE OF BURIAL. May 30 19 24

20-UNDERTAKER. Jack Lewis — ADDRESS 1439 E Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 87405

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

74 D 87405

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital,

CITY OF BALTIMORE: (No. Monument St. & Rutland Ave. WARD 15)

2-FULL NAME Mrs Max Klasman

(a) RESIDENCE No. 143 No. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Klasman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isidore Klasman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dintam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1439 E Baltimore

15 FILED MAY 29 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/20, 1924, to 5/28, 1924,

that I last saw him alive on 5/25, 1924,

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Thrombo-angiitis obliterans

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/26/24

Was there an autopsy? No. Supplementary.

What test confirmed diagnosis?

(Signed) A. Adler Goldbeyer M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northern circle Cem DATE OF BURIAL 5/29 1924

UNDERTAKER Jack Levis ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87406

CERTIFICATE OF DEATH.

170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Scott st- ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mr. John Stauffer

(a) RESIDENCE NO. 1127 Scott st- ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 27-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Packer - 86
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto Bargain House

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John Stauffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Seubert

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs Mary Stauffer
(Address) 1127 Scott St

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
MAY 29 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound in Brain

(duration) a few minutes ds.

CONTRIBUTORY (Secondary) Suicide

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch, M. D.
(Coroner.)

5-29, 192 (Address) 917 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL May 31 1924

20 UNDERTAKER Jos H Moran - Son ADDRESS 901 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 87407 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 90 29 D 87407

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General St. ... Ward)

2-FULL NAME Alice M. Wiegand

(Residence in Baltimore: No. 2547 Hollins St — St.; yrs. 40 mos. ... ds. K 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: white

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.): widow

6-DATE OF BIRTH: Aug 3rd (Month) (Day) 1879 (Year)

7-AGE: 44 yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Rosie M Wiegand

(Address) 2547 Hollins St

15- MAY 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk. 192...

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27th (Month) (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Enter. Nephritis

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

May 29 1924 (Address) 5 E Eden St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL, May 30 1924

20-UNDERTAKER: John J. Conway Sr. ADDRESS 901 Gay St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87408 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87408

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. St Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm McDonough

(a) Residence No. St Mary Indus. School St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Unknown

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6-DATE OF BIRTH (month, day and year): Unknown 1854

7-AGE: 70 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): 062
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14- (Informant): Mrs Mary Sterling
(Address) 3042 S Stafford St

15-

MAY 29 1924 ROBERT B. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 29-24

17- I HEREBY CERTIFY, That I attended deceased from May 16 19 24 to May 29 19 24 that I last saw h... alive on May 29 19 24 and that death occurred, on the date stated above, at 1.40 AM

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonic

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Symptoms

(Signed) A. Goldman M. D

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL, May 30. 1924

20-UNDERTAKER, Chas P. Maus & Son — ADDRESS 1 W Mt Royal Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 Ensor ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Woolery

(a) RESIDENCE NO. 729 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, ~~(write the word)~~: Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Woolery

6 DATE OF BIRTH (month, day, and year): Aug 18th 1848

7 AGE: Years 75 Months 9 Days 10 If LESS than 1 day,.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md

PARENTS

10 NAME OF FATHER: Lloyd Shriver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Ella Bell

(Address): 729 Ensor st

15 Robert P. Harrison Registrar

MAY 29 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1924, to May 28, 1924,

that I last saw he alive on May 28, 1924

and that death occurred, on the date stated above, at. 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) V. E. Reynolds M.D.

(Address) 1531 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery — DATE OF BURIAL: May 31st 1924

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 1126 E Monument st

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87410

CERTIFICATE OF DEATH.

D 87410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

2-FULL NAME Horace E. Beane

(a) RESIDENCE NO. Lancaster Co., Va. ST., WARD Lancaster Co. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 17, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Va

PARENTS

10 NAME OF FATHER Horace Beane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Horace Beane
(Address) Va

15 JUN 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-24

17 I HEREBY CERTIFY, That I attended deceased from 5-28-24 to 5-29-24,

that I last saw him alive on 5-29-24,

and that death occurred, on the date stated above, at 6 15 a m.

The CAUSE OF DEATH* was as follows:

Cerebro spinal Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture

(Signed) Myron G. Tull, M. D.

, 19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Co Va	may 30, 24
20 UNDERTAKER	ADDRESS
Chenoweth Son	367 Chestnut Ave

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87411

HEALTH DEPARTMENT—CITY OF BALTIMORE D 87411

CERTIFICATE OF DEATH.

159-0

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1737 E. Preston Street ST., 8 WARD)

2-FULL NAME John H. Appel

(a) RESIDENCE NO. 1737 E. Preston Street ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? Life yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 16, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2		

8 OCCUPATION OF DECEASED None
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Appel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Myrtle M. Blight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John Appel 1737 E. Preston St.

15 Filed MAY 29 1924, 19 ..... Robert F. Harris Registrar
Medical Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 29 1924

17 I HEREBY CERTIFY, That I attended deceased from APR 10 1924, 19..., to MAY 29 1924.
that I last saw him alive on MAY 29 1924,
and that death occurred, on the date stated above, at 9.55 A m.
The CAUSE OF DEATH* was as follows:
General Toxemia

(duration) X yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Marasmus (duration) ... yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of X
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) O. H. Dunker, M. D.
(Address) 928 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore, Cemetery	5/31 1924
20 UNDERTAKER Albert L. Hiltz, Jr.	ADDRESS 1606 N. Chester st

MAY 29 1924

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87412

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 S. Wolfe St. ST.: V WARD)

2-FULL NAME Catherine Stunt

(a) RESIDENCE. No. 704 S. Wolfe St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Stunt.

6 DATE OF BIRTH (month, day, and year) Nov. 25-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress 58

(b) General nature of industry, business, or establishment in which employed (or employer) Eastern Police Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jeremiah Finn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Johanna Coughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Anthony Stunt. (Address) 704 S. Wolfe St.

15 [illegible] 19 Robert P. Harrison, Registrar

MAY 29 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 26, 1924, that I last saw her alive on May 25, 1924 and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gm — M. D.

M. 19 24 (Address) 622 N. Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem.	May 30 1924
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 S. Wolfe St.

THIS IS A PERMANENT RECORD. Every item must be written in PERMANENT, WITH UNFADING INK—THIS IS A LAW. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87413

CERTIFICATE OF DEATH.

1+90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3300 WINDSOR AVE St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME HENRY HARRISON BURNHAM.

(a) Residence No. Jewett City, Connecticut. St., ... Ward Jewett City, Conn.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sophia L. Bennett

6-DATE OF BIRTH (month, day and year) Aug 2-1845

7-AGE. 78 yrs. 9 mos. 21 ds. | If LESS than 1 day, ..hrs. or ..min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Lawyer and Judge
(b) General nature of industry, business, or establishment in which employed (or employer)..... —
(c) Name of employer..... —

9-BIRTHPLACE (city or town) (State or Country). Coventry, R. I.

PARENTS.

10-NAME OF FATHER. Andrew Clark Burnham

11-BIRTHPLACE OF FATHER (city or town) (State or Country). NORWICH, CONN.

12-MAIDEN NAME OF MOTHER. CYNTHIA CRUFF REMINGTON

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Coventry R.I.

14- (Informant) Alfred H. Burnham
(Address) 3300 WINDSOR Ave Balto. Md.

15- Robert P. Garrison, Registrar.

MAY 29 1924

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH. 10.30 P.M.

16-DATE OF DEATH (month, day and year) May 28-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan-1- 1924 to May 28- 1924

that I last saw him alive on May 28 1924

and that death occurred, on the date stated above, at 10.30 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency due to age, and chronic myocarditis.

(Duration) yrs. 6- mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary congestion due to heart failure

(Duration) yrs. mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wesley Gale M. D.

5/29, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Norwich Conn	May 29. 1924
20-UNDERTAKER.	ADDRESS
Wm. Tucker & Sons	North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87414

CERTIFICATE OF DEATH.

X 101 D 87414

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fareed Mohideen

(a) RESIDENCE NO. British Steamer CROSBY HALL ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. 15 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	HINDU	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) British Steamer

(c) Name of employer CROSBY HALL

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Martin Lilly Company
(Address) Equitable Building

15 Filed MAY 29 1924 Robert P. Harris, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to May 28, 1924, that I last saw h/M alive on May 28, 1924, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? On board ship.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Wm Boor M. D.

5-29 1924 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL May 30 1924

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Bond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—P.B.R.S.—400 Blks.

Stinchcomb

D 87415 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 16 74 001

City of BALTIMORE: (No. 2753 Raynor Avenue St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Stinchcomb

(a) Residence No. 2753 Raynor Avenue St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson P. Stinchcomb

6-DATE OF BIRTH (month, day and year) Dec. 5, 1835

7-AGE, 88 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). Baltimore County
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, Thomas Dickson Fowler

11-BIRTHPLACE OF FATHER (city or town). New Jersey
(State or Country).

12-MAIDEN NAME OF MOTHER, Rachel Brennan

13-BIRTHPLACE OF MOTHER (city or town). Balto. County
(State or Country). Maryland

14- (Informant). Mr. Byron Stinchcomb

(Address) 2753 Raynor Avenue

15- Filed Robert F. Harris, Registrar.

MAY 29 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 28, 1924

17- I HEREBY CERTIFY, That I attended deceased from June, 19 23 to date of death, 19..., that I last saw h.. alive on May 28, 19 24, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Death was due to Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mathew Le Davis, M. D.

5-28, 19 24 (Address) 824 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, May 31" 1924
Loudon Park Cem	
20-UNDERTAKER, Joseph B Cook	ADDRESS 1003 N Balto

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87416

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87416

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1409 Wash. Boulevard St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Robert D. Innerst

(a) Residence No. 1409 Wash. Boulevard St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Innerst

6-DATE OF BIRTH (month, day and year) April 6 1852

7-AGE.	If LESS than 1 day,
72 yrs. 1 mos. 1 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None 040

(b) General nature of industry, business, or establishment in which employed (or employer)..... Laboring

(c) Name of employer..... None

9-BIRTHPLACE (city or town)..... Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Michael Innerst

11-BIRTHPLACE OF FATHER (city or town)..... Pa.
(State or Country),

12-MAIDEN NAME OF MOTHER, Margaret A. Hoke

13-BIRTHPLACE OF MOTHER (city or town)..... Pa.
(State or Country),

14-
(Informant)..... X .....
(Address)..... 1409 Wash. Boulevard .....

15-
(Filed)..... 19?
Registrar.

Robert P. Harris M.D.

Y2 91324

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27 24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1923, to May 27, 1924, that I last saw him alive on May 27, 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

.....

.....

.....(Duration).....yrs. 6 mos.....ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Culture

(Signed) Harry Boyle M. D.

May 27, 1924 (Address) 602 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19?.
Greenmount	
20-UNDERTAKER.	ADDRESS
Wm. Buchheister	

A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Mercer

D 87417

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87417

CERTIFICATE OF DEATH.

1874-00

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 16 S. Schroeder St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert T. Mercer .....

(a) Residence No. 16 S. Schroeder St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Katie C. Mercer

6-DATE OF BIRTH (month, day and year) Sept. 3, 1842

7-AGE,	If LESS than 1 day,
82 yrs. 8 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establisbment in which employed (or employer)..... Laborer

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Howard County
(State or Country). Maryland

PARENTS.

10-NAME OF FATHER, John Mercer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Agnes Warfield

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland

14- (Informant)..... Mrs. Katie C. Mercer
(Address)..... 16 S. Schroeder Street

15- Filed ..... Robert P. Harrison, Registrar.

MAY 29 1924

Burial Permit Cert.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from 5/10/, 1924, to 5/29/24, 19.....

that I last saw h... alive on 5/28/24, 19.....

and that death occurred, on the date stated above, at 7.30 m

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Chr. Diff. Nephritis

chr. Hypertension

History (Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage, &c.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical,

(Signed) Edward J. Tracy, M. D.

5-29, 1924 (Address) 910 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mt. Henry's Cem. Howard Co. Maryland	May 31, 1924
20-UNDERTAKER, Roark B. Cook	ADDRESS 1003 W. Balto. St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

A PERMANENT RECORD. Every item of information

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87418

CERTIFICATE OF DEATH.

1/101-001

D 87418

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hosp. WARD) 15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Mae Leisure

(a) RESIDENCE NO. Rehr Home ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13th 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	10	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry S. Leisure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jennie Fuller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Jennie Leisure

(Address) 1524 Riggs Ave

MAY 30 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-28, 1924, to 5-29, 1924

that I last saw her alive on 5-29, 1924

and that death occurred, on the date stated above, at 12 20 A m.

The CAUSE OF DEATH* was as follows:

Chorea; 1 month;
Pneumonia (lobar) 3 da

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis; myocarditis. pericarditis (duration) yrs. mos. 3 hrs last

18 Where was disease contracted if not at place of death? State Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Jno A Stump Jr M. D.

, 19 (Address) MD Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Western Cem	May 31 1924
20 UNDERTAKER	ADDRESS
E Schlosnagle Son	Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87419

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87419

CERTIFICATE OF DEATH.

181-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 W. North Ave ST., 13 WARD)

2-FULL NAME Ina Alice Mary Hilleg

(a) RESIDENCE NO. 638 W. North Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Jos E. Hilleg

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John McMullen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unk

14 Informant Chas McColgan
(Address) 21 Calvert St

15 Filed MAY 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Femur
Accidental fall

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

May 29, 1924 (Address) 3612 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 5-30 1924

20 UNDERTAKER Henry W. Jenkins' Son Co

ADDRESS Orchard & Calhoun

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87420

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

148 D 87420

Registered No.....

City of BALTIMORE: (No. 51 Raspe Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Louise Weiss

(a) Residence No. 51 Raspe ave St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Chas W. Weiss

6-DATE OF BIRTH (month, day and year) Apl 21/94

7-AGE. 30 yrs. 1 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, Glenn Doged

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER, Kate ~~not known~~

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14-

(Informant)..... Chas. W. Weiss

(Address)..... 51 Raspe ave

MAY 30 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/28/24

17- I HEREBY CERTIFY, That I attended deceased from May 27 1924 to May 28 1924

that I last saw h.e alive on May 28 1924

and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

Fetal & Uncinal

(Duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Pregnancy

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Albuminuria

(Signed) S. Swanger M D

5/30 1924 (Address) 1014 S. Ellwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Lorraine	5/30, 1924
20-UNDERTAKER Philip Herrig	ADDRESS 2014 Orleans St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8742L

CERTIFICATE OF DEATH.

101-001 D 8742L

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 University Parkway St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Halliday Thomas Bullock

(a) Residence No. 920 University Parkway St., 27 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? 46 yrs. 7 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Findley H. Bullock

6-DATE OF BIRTH (month, day and year) Oct 4 1877

7-AGE, 46 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Saml L. Thomas

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Mary Halliday

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Mr F. H. Bullock

(Address) 920 University Parkway

15- Filed MAY 30 1924 192

ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/28/24

17- I HEREBY CERTIFY, That I attended deceased from 5/24/24, 19..., to 5/27, 1924 that I last saw her alive on 5/27, 1924 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration)...yrs...mos. 4 ds.

CONTRIBUTORY (Secondary) Multiple arthritis

(Duration) 9 yrs...mos...ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. E. Bebelaar, M. D.

5/28, 1924 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL, May 30, 1924

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM P. MOWEN, Successor)

ADDRESS 102 W. NORTH AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh... In plain terms, so that it may be properly classifie... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

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THANK

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87422

CERTIFICATE OF DEATH.

8 74-001 D 87422

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1522 Collington Av St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Elmer Rice

(a) Residence No. 1522 N. Collington Av St., 8 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 72 yrs. 0 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Jenkins Rice

6-DATE OF BIRTH (month, day and year) May 24 1852

7-AGE, 72 yrs. 0 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer none

9-BIRTHPLACE (city or town) West Dover (State or Country), Vermont

PARENTS.

10-NAME OF FATHER, George E. Rice

11-BIRTHPLACE OF FATHER (city or town) West Dover (State or Country), Vermont

12-MAIDEN NAME OF MOTHER, Eliza A. Mills

13-BIRTHPLACE OF MOTHER (city or town) Montague (State or Country), Mass.

14- (Informant) Mason Rice - (Son)
(Address) 1522 N. Collington Av

15- Filed MAY 30 1924 ROBERT R. KRAUTER, Burial Permit Officer.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). MAY 28 1924

17- I HEREBY CERTIFY, That I attended deceased from MAY 19 1924, 19....., to MAY 27 1924, 19.....
that I last saw h. l. alive on ....., 19.....,
and that death occurred, on the date stated above, at 10:40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) X yrs. X mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) ? yrs. ? mos. ? ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X X

Was there an autopsy? No

What test confirmed diagnosis? None except a urinalysis

(Signed) O. H. Dukes M. D.

MAY 28 1924 (Address) 928 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, May 30 1924

20-UNDERTAKER, STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AV.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required to make a PERMANENT RECORD of all facts stated. Exact statement of OCCUPATION is necessary. Cause of death must be properly classified. Use only words sanctioned by the Standard Nomenclature of Diseases. Write in plain terms, so that it may be properly classified

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87423

CERTIFICATE OF DEATH. 159-002

D 87423

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Hanbert ST., 24 WARD)

2-FULL NAME Jacob Krach

(a) RESIDENCE NO. 1442 Hanbert ST., — WARD —
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 29-1924

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or — min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Jacob Krach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Rosa Roschauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant (Address) John Rosenauer 1442 Hanbert St

MAY 30 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1924

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.

3 hours.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

, 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co.

DATE OF BURIAL May 30 1924

20 UNDERTAKER Chas. L Stevens

ADDRESS 1501 E Fort Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87424

CERTIFICATE OF DEATH.

74-001 D 87424

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 Dolphin St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Guyton

(a) Residence No. 309 Dolphin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single. ~~Married, Widowed, or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Nov 18-1837

7-AGE. 86 yrs. 6 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Joshua Guyton

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Elizabeth McClasher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant) Richard S. Guest

(Address) 425 N. Carey St

15-Filed MAY 30 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 29/24

17- I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ March 14 1924 to May 29 1924 that I last saw h~~er~~ alive on May 28 1924 and that death occurred, on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

Arterio Sclerosis

(Duration) 2½ mos.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History - Symptoms

(Signed) Edwin K. Ballard M. D

5-29 1924 (Address) 1622 Mt Royal Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cem — DATE OF BURIAL. May 31 1924

20-UNDERTAKER. Wm Fickner Sons — ADDRESS Hotel Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 87425

CERTIFICATE OF DEATH. 129

D 87425
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2424 Edmondson Ave 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Seward

(a) Residence No. 2424 Edmondson Ave St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Seward

6-DATE OF BIRTH (month, day and year) Nov 26 1840

7-AGE. 83 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) Phila
(State or Country), Pa

PARENTS.

10-NAME OF FATHER, Horatio Wallace

11-BIRTHPLACE OF FATHER (city or town) Phila
(State or Country), Pa

12-MAIDEN NAME OF MOTHER, Elizabeth Conlin

13-BIRTHPLACE OF MOTHER (city or town) Phila
(State or Country), Pa

14- (Informant) Mrs Mary E Weaver
(Address) 2424 Edmondson

15- MAY 30 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 15 1924 to May 29, 1924
that I last saw h.. alive on May 28 1924
and that death occurred, on the date stated above, at 2.10 a.m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(Duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Old age
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory

(Signed) Jas. E. Lumpkin M. D
May 30, 1924 (Address) 818 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Cem — DATE OF BURIAL. May 31, 1924

20-UNDERTAKER. Wm Pickier & Sons — ADDRESS Nord. Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Cor.—1-12-21—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87426

CERTIFICATE OF DEATH. X 188-003

D 87426

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Caroline E. Lauer

(a) RESIDENCE No 54 Sudbrook Ave Pikesville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Lauer

6 DATE OF BIRTH (month, day, and year) May 9/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	52		19??	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Buschman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Burhurc

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Interment Caroline Estelle Nicholls (Address) Sudbrook Park

15 MAY 3 0 1924 ROBERT R. KRAUTER Registrar Asst. Vital Statistics Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28-24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & other injuries
Struck by automobile

(Inquest to be held) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S H Owens, M. D. (Coroner.)

May 29/24 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	May 31 192 4
20 UNDERTAKER Burkhart & Burkhart	ADDRESS Eager

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Morrissey

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87427

CERTIFICATE OF DEATH.

188-006

D 87427

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 500 Block Lemmon ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincenzo Vacca

(a) RESIDENCE NO. 809 Low Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

8a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Dolgissina Vacca

6 DATE OF BIRTH (month, day, and year) May 21-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Construction
(c) Name of employer Carmillo Jacoponi

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Dolgissina Vacca
(Address) 809 Low Street

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MAY 30 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day ~~stated~~ above.

The CAUSE OF DEATH was as follows: Internal Injuries due to Fall & Fracture of Skull as the result of Accidental Injuries

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. J. Morrissey M. D.
(Coroner.)

May 29 1924 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 809 Low Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	5/31/1924
20 UNDERTAKER William Cook	ADDRESS 502 E North Ave

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be p
TION is very important. See instructions on back of c

Cor.—1-12-23—M&T—100 Bks. Richard J McCullough

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 87428

CERTIFICATE OF DEATH.

90 D 87428

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 3811 Eastern Ave. No ST., ... WARD)

2-FULL NAME Richard J. McCullough.

(a) RESIDENCE NO. Philadelphia Road at Bayleys Lane ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna McCullough

6 DATE OF BIRTH (month, day, and year) May 19-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Dorthman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Dorthman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ' '

14 Informant Anna McCullough
(Address) Philadelphia Road & Bayleys Lane

15 Filed ....., 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos Edwin Blake, M. D.
(Coroner.)

5-28-24, 192 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	May 30 1924
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E. Balt.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87429

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 942 S. East ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie W. Blische

(a) RESIDENCE NO. 942 S. East ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Adolph Blische

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Marian Swanson

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Md.

14 Informant Marian Blische
(Address) 942 S. East Ave

15 MAY 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1924

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1924, to May 29, 1924.

that I last saw her alive on May 28, 1924.

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) B. Bronstein, M. D.

May 29, 1924 (Address) 3037 Ordnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bachmans Cemetery

DATE OF BURIAL June 1 1924

20 UNDERTAKER Grikler & Grikler

ADDRESS 1739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87430

CERTIFICATE OF DEATH.

129 D 87430

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2537 Boyd St St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elie L. Zimmers

(a) Residence No. 2537 Boyd St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret A Zimmers

6-DATE OF BIRTH (month, day and year) April 28/1845

7-AGE. 79 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Huckster

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Lancaster Co. Pa.

PARENTS.

10-NAME OF FATHER, Jacob Zimmers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14 (Informant) Margaret A Zimmers

(Address) 2537 Boyd St

15 MAY 30 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 28. 24

17- I HEREBY CERTIFY, That I attended deceased from May 26 1924 to May 28 1924

that I last saw h[illegible] alive on May 28 1924

and that death occurred, on the date stated above, at 5 8 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cox M. D.

5/29, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park Cemetery — DATE OF BURIAL, May 31, 1924

20-UNDERTAKER, Harry N Amacoat — ADDRESS 4204 Ridgewood Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 10ks.

(7225) 87431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32

D 87431

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Charles Henderson

(a) RESIDENCE No. 700 Cyburn Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred City mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE~~ of Anna

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	-	-	

8 OCCUPATION OF DECEASED ?

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Gazel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 30 1924 ROBERT N. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th 24

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to May 25, 1924.

that I last saw him alive on May 25, 1924.

and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Tubercle Brain (Bns)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Observation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 5/18/24

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Julian F. Hayt. M. D.

, 19 (Address) 1818 ?

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. E. Hughes DATE OF BURIAL 5/31/24

20 UNDERTAKER 4242 Broadway ADDRESS Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87432

CERTIFICATE OF DEATH.

129 D 87432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N Fulton Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E Smith

(a) RESIDENCE NO. 616 N Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J Smith

6 DATE OF BIRTH (month, day, and year) Jan 29 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Thaddeus Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McCarney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant Mrs Ella M Warnefield
(Address) 1823 W Fayette st

15 Filed MAY 30 1924 ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 28, 1924,

that I last saw her alive on May 28, 1924,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

and Myocarditis.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 6 yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard L Friend, M. D.

May 29, 1924 (Address) 1707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/1 24 19
20 UNDERTAKER Jno C Tully	ADDRESS Fulton & Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87433

Registered No.....

1-PLACE OF DEATH 82 Main St

City of BALTIMORE: (No. Hillsdale St., 28 Ward) 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles D. Martin

(a) Residence No. Hillsdale St., Ward W. Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) married

5a-If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Alice Maiten

6-DATE OF BIRTH (month, day and year) Dec 26 1867

7-AGE. 57 yrs. 5 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer). Plasterer 057

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Boonsville - W Va.

PARENTS.

10-NAME OF FATHER. Jasper Maiten

11-BIRTHPLACE OF FATHER (city or town) (State or Country). W Va.

12-MAIDEN NAME OF MOTHER. Nancy Slocomb

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). W Va

14- (Informant) Mrs Stella Lenering

(Address) Hillsdale

15- Filed MAY 3 0 1924 192 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 27-1924

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1924 to May 27 1924

that I last saw him alive on May 26 1924

and that death occurred, on the date stated above, at 2 A.M. P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

+ Liver

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

+ Liver (Duration) 7 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray & Physical

May 27 19 (Signed) Walter S Tibbitt M. D.

(Address) 2220 Harrison Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodbine	May 31, 1924
20-UNDERTAKER.	ADDRESS.
Geo L Schwab & Sons	Frederick Md

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 87434

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Light St ST.: 23 WARD)

2-FULL NAME Bessie E. McInulty

(a) RESIDENCE. No. 1510 Light St ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Patk. McInulty

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Chas. Hanly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Florence McInulty (Address) 1510 Light St

15

MAY 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1924, to May 28, 1924, that I last saw h alive on May 28, 1924, and that death occurred, on the date stated above, at 6 40P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Becker Brack, M. D.

May 29 1924 (Address) 1412 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/31 1924
20 UNDERTAKER	ADDRESS
J. Sidney Stone	1318 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87435

CERTIFICATE OF DEATH.

63

D 87435

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 18 WARD)

2-FULL NAME Christopher Kimball

(a) RESIDENCE NO. 1208 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Dec 3 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Police

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Officer 161

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Charles Kimball

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Annie Webber

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant (Address) Hospital Record

15 Filed ....., 19 ..... ROBERT R. KRAUTER Registrar

MAY 30 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28/24

17 I HEREBY CERTIFY, That I attended deceased from 5/12/24, 19..... to 5/28/24 19 .

that I last saw h— alive on 5/28/24, 19 .

and that death occurred, on the date stated above, at 6. a m.

The CAUSE OF DEATH* was as follows:

Probably Arteriosclerosis Dementia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Vincent's Angina

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gallery, M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	May 31 1924

20 UNDERTAKER Margt G Flynn ADDRESS 422 Light

Spec.—1-19-21—M&T—1500 Bks.

D 87436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 23 D 87436

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin C. Jones

(a) RESIDENCE No. Union Memorial Hosp. ST., 17 WARD New York

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 19 ds. How long in U. S., If of foreign birth? 43 yrs. 6 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 065

(b) General nature of industry, business, or establishment in which employed (or employer) Missionary to China

(c) Name of employer Self.

9 BIRTHPLACE (city or town) New York (State or country) New York

PARENTS

10 NAME OF FATHER Robert W. Jones

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)

12 MAIDEN NAME OF MOTHER Elsie L. Solles

13 BIRTHPLACE OF MOTHER (city or town) Conn. (State or country)

14 Informant Roy H. Jones (Brother.) (Address) Caswell Hotel

15 FILED MAY 31 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1924, to May 30, 1924, that I last saw him alive on May 30, 1924 and that death occurred, on the date stated above, at 5 08 A m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(duration) yrs. 15 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? China

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Donald C. Chandler, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norwalk-Conn. DATE OF BURIAL May 30 19 24

20 UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 108 W. NORTH AVE.

Burial Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87437

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 167 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Madeline Depk

(a) Residence No. 1317 Hollins St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (Write the word.)

5a-If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE~~ of Widow

6-DATE OF BIRTH (month, day and year) ?

7-AGE: 65 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ohio

PARENTS.

10-NAME OF FATHER: Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12-MAIDEN NAME OF MOTHER: Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14-(Informant): Mrs Neuby

(Address): 1317 Hollins St.

15-FILED: 1924 Robert E. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 28-24

17- I HEREBY CERTIFY, That I attended deceased from May 25 19 24 to May 28 19 24

that I last saw h.. alive on May 28 19 24

and that death occurred, on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism
Hemiplegia
Cardiac Hypertrophy
Auricular Fibrillation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 4 days

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H O Harper M. D

, 19 (Address) Edgewood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: WOODLAWN CEMETERY — DATE OF BURIAL: MAY 31 1924

20-UNDERTAKER: ROBERT BROOKS & SON — ADDRESS: CALHOUN & HOLLINS ST

Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

D 87438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87438

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Gertrude V. Dryden

(a) RESIDENCE NO. 1715 East 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Isaac H. Dryden

6 DATE OF BIRTH (month, day, and year) Mar. 11, 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pocomoke, Md.

PARENTS

10 NAME OF FATHER Wm. Robt Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Farlane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Isaac H. Dryden (Address) 1715 E. 25th St

15 Filed MAY 31 1924, 19 Robert P. Harris Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1923, to May 30, 1924.

that I last saw her alive on May 30, 1924,

and that death occurred, on the date stated above, at 3:10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 9 mos 6 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. A. Sussman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke Md via P.R.R

DATE OF BURIAL May 31, 24

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87439 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87439

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore

City of BALTIMORE: (No. 4922 Hartford Ave. St., 27 Ward)

Registered No. 159

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lawrence Clayton Brooks

(a) Residence No. 4922 Hartford Ave. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M.	N.	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 11, 1924

7-AGE.	If LESS than 1 day,
..... yrs. 6 mos. 18 ds.	....hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Brooks

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Olive Armstrong

13-BIRTHPLACE OF MOTHER (city or town) England (State or Country),

14- (Informant) Olive Armstrong

(Address) 4922 Hartford Ave.

15- Recorded [illegible] 192

Registrar.

MAY 31 1924 [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 28/24

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11 19 23 to May 28 19 24

that I last saw him alive on May 28 19 24

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Jos. J. Schulte, M. D

, 19 Address 4410 Hartford Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cem.	May 31, 1924

20-UNDERTAKER.	ADDRESS
George J. Roth	1735 Hartford Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87440

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 87440

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N. Carey St., ST., 16 WARD)

2-FULL NAME James Godfrey

(a) RESIDENCE NO. 1112 N. Carey St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 040

9 BIRTHPLACE (city or town) (State or country) Norfolk, Va.

PARENTS

10 NAME OF FATHER Daniel Godfrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Catherine Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Oscar Godfrey (Address) 42 W. 133rd St. N.Y. City

15 Filed ..... 192 Robert F. Harris Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)

May 30, 1924 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL MAY 31 1924 192

20 UNDERTAKER Samuel D. Dowden

ADDRESS 711 Eddley St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 87441

1-PLACE OF DEATH

City of BALTIMORE: (No. 2 - Derry Ave. St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Smith

(a) Residence No. 2 Derry Ave St.,.....Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, col

5-Single, Married, Widowed, or Divorced, (Write the word.) widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coachman

(b) General nature of industry, business, or establishment in which employed (or employer) 823

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), unknown

14- (Informant) Robert Smith

(Address) 2 Derry Ave N Roland Park

15- Filed MAY 31 1924 Robert P. Harris Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to May 27, 1924, that I last saw h... alive on May 27, 1924, and that death occurred, on the date stated above, at 10-30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Plane Death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) R. A. Johnson, M. D.

May 30, 1924 (Address) 211 - E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL MAY 31 1924

20-UNDERTAKER James H. Crowley — ADDRESS 678 N. Eden St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information

MAY 31 1924

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87442

CERTIFICATE OF DEATH.

17 D 87442

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John S Sterling

(a) RESIDENCE NO. Loyola College (Usual place of abode) Baltimore WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profesaion or particular kind of work 086

(b) General nature of Industry, business, or establishment in which employed (or employer) Janitor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sidney Sterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind.

12 MAIDEN NAME OF MOTHER Cordelia Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Hospital Record

15 Filed Y 3 1924 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29-1924

17 I HEREBY CERTIFY, That I attended deceased from 5-17-24, 19..., to 5-29-24 19..., that I last saw h— alive on 5-29-24 19..., and that death occurred, on the date stated above, at 3 09 m.

The CAUSE OF DEATH* was as follows:

Liver abscess

(Primary Cause unknown)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ? Reporting ordinary

Did an operation precede death? Yes Date of 5-23-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) K. W. Golley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	5/31 1924
20 UNDERTAKER	ADDRESS
M. C. Mears & Son	805 N. Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87443

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87443

CERTIFICATE OF DEATH.

4 74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 7 W. Franklin St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Ferdinand D. Crace

(a) Residence No. 7 W. Franklin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Angelina D. Crace

6-DATE OF BIRTH (month, day and year) Don't Know

7-AGE.	If LESS than 1 day,
75 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Italy

14- (Informant) Clement D. Crace

(Address) 7 W. Franklin St

15- Robert F. Harrison, Registrar.

Burial Permit Issued 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 29th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 27 1924 to May 30 1924 that I last saw h[illegible] alive on May 27 1924 and that death occurred, on the date stated above, at 1-9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Cerebral Hemorrhage)
2nd attack (Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion
Arteriosclerosis (Duration) 8 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Constantine, M. D.

May 30, 1924 (Address) 1038 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer Cem	May 31, 1924
20-UNDERTAKER,	ADDRESS
John Mellor	2008 Eutaw

Y3

WRITE LEGIBLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87444

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87444

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount St., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Adelaide Senge (Senge)

(a) RESIDENCE No. 430 N. Patterson Park Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wendelin Senge

6 DATE OF BIRTH (month, day, and year) Nov 4-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown Gungermas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wendelin Senge

(Address) 430 N. Patterson Park Ave.

15 Filed MAY 31 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1924, to May 30, 1924, that I last saw h[illegible] alive on May 30, 1924, and that death occurred, on the date stated above, at 9:35a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Cholecystitis Cholelithiasis

Nephritis, Chronic

(duration) ..... yrs. ..... mos. 3 wks

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 2 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy.

(Signed) Cary Nevin Vanetten M. D.

, 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	June 2 1924
20 UNDERTAKER	**ADDRESS**
H. Sander & Sons	1710 Fleet St.

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87445

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Lukes Gen Hosp ST., 23 WARD)

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Moran.

(a) RESIDENCE No. 1538 S Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Mary A Moran

6 DATE OF BIRTH (month, day, and year): Oct 12-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	74	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Police officer 161

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Baltimore City

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant. (Address): Ed Hughes 1436 Patapsco ST

15 MAY 31 1924 Robert P. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to May 29, 1924

that I last saw h[illegible] alive on May 29, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Incarcerated Hernia

Incarcerated (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 29/24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Oliver, M. D.

(Address) Saint Lukes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemy

DATE OF BURIAL: June 2 1924

20 UNDERTAKER: Mrs. Christian Miller

ADDRESS: 2334 Jefferson St

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1322 Wyoming Ave ST., 23 WARD)

2-FULL NAME Mrs Catherine Bunn

(a) RESIDENCE NO. 1322 Wyoming Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gilbert L. Bunn

6 DATE OF BIRTH (month, day, and year) Dec 24-1843

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John L. Lutz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara A. Hook

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wm. H. Hamilton
(Address) 1322 Wyoming Ave

15 Filed MAY 31 1924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1924, to May 29, 1924,

that I last saw h alive on May 29, 1924

and that death occurred, on the date stated above at 6 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Insufficency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Harry C. Alger M. D.

5 30 1924 (Address) 5640 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL May 31 1924

20 UNDERTAKER Horace G. Burgee — ADDRESS 5601 Falls Rd

N.B.—WRITE PLAINLY, WITH UNFA... INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificates.

D 87447

Spec.—6-6-19—H. P. Co.—1000 Bks.

D 87447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2551 Florence ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Priscilla Boxley.

(a) RESIDENCE. NO. 2551 Florence ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant (Address) Mary Golden 2539 Florence St

15 Filed MAY 31 1924, 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to May 29, 1924, that I last saw h[illegible] alive on May 29, 1924, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Regular.

(Signed) F. C. Fink, M. D.

May 29-1924 (Address) North Ave & Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 31 1924
20 UNDERTAKER Joseph A Farrell	ADDRESS 2318 Druid

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87448

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87448

CERTIFICATE OF DEATH.

5 74-901

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1425 Jefferson St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Levin H. Lee

(a) Residence No. 1425 Jefferson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	colored	~~married~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 67 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)... 040

(c) Name of employer...

9-BIRTHPLACE (city or town)... (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Thomas Lee

11-BIRTHPLACE OF FATHER (city or town)... (State or Country). Md

12-MAIDEN NAME OF MOTHER. Caroline Burrs

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country). Md

14- (Informant)... Mary L. Lee

(Address) 1425 Jefferson St

15- Filed ... 19... Robert E. Harrison Registrar.

MAY 31 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29-24

17- I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to May 29, 1924, that I last saw h. m. alive on May 29, 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Two days (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

5-30, 1924 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Asbury Cemetery	June 1, 1924
20-UNDERTAKER.	ADDRESS
Mrs Chas L. Bailey	1421 Jefferson St

Signed Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87449

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87449

CERTIFICATE OF DEATH.

Registered No. 43

1-PLACE OF DEATH

City of BALTIMORE: (No. 3403 Garrison Av St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Magdalene Prechtel

(a) Residence No. 3403 Garrison Av St., 15 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? 75 yrs. 11 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. F. Prechtel

6-DATE OF BIRTH (month, day and year) June-15-1848

7-AGE. 75 yrs. 11 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS.

10-NAME OF FATHER Henry Schillinger

11-BIRTHPLACE OF FATHER (city or town) unknown (State or Country). Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) unknown (State or Country). unknown

14- (Informant) Mrs. Jno McMullen (daughter)

(Address) 1630 Linden Ave City

15- Filed MAY 31 1924, 19.. Robert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29/24

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24, to May 29, 19 24, that I last saw h.. alive on May 29, 19 24, and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hazard, M. D.

, 19 (Address) 225 W Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL, May 31 19 24

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

THIS IS A PERMANENT RECORD. WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

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in plain terms, so that it may be properly classified. E
instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87450 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87450

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 90

City of BALTIMORE: (No. Earl Court Apts St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Lee Webb

(a) Residence No. Earl Court Apts St., 11 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? 71 yrs. 3 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Florena Malsbery Webb

6-DATE OF BIRTH (month, day and year) Feby-11-1853

7-AGE. 71 yrs. 3 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Pay Master 086

(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept.

(c) Name of employer City of Baltimore

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER Albert Lee Webb

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Catherine Deford

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mrs. Florence M. Webb Wife
(Address) Earl Court Apts.

15- Filed MAY 31 1924, 19.. Robert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29 1924

17- I HEREBY CERTIFY, That I attended deceased from March 17 1924, to May 29 1924, that I last saw h.. alive on May 28 1924, and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Lawrence E. Beach M. D.

, 19 (Address) 2231 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Hill Cemetery — DATE OF BURIAL. May 31st 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87451 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87451

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 2003 Smallwood St. (or Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Elsie Spence

(a) Residence No. 3127 Cedar Ave. St. ..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Spence

6-DATE OF BIRTH (month, day and year) Nov 10 1899

7-AGE, 24 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER Augusta Isenhood

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md

12-MAIDEN NAME OF MOTHER Johnana A. Clemens

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md

14- (Informant) Edward Spence (Address) 2003 Smallwood St

15- Robert P. Harris Registrar.

MAY 31 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1923 to May 29 1924

that I last saw h... alive on May 29 1924

and that death occurred, on the date stated above, at 9.35 P m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis.

.....(Duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

.....(Duration)..... yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy? not

What test confirmed diagnosis? Pathologic

(Signed) Chas. F. Bryden, M. D.

May 31 1924 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet Cem	June 2 1924
20-UNDERTAKER	ADDRESS
CRENOWETH & SON,	2117 CHESTNUT AVE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87452

CERTIFICATE OF DEATH.

90 D 87452

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 Harford Ave. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Vansant,

(a) RESIDENCE No. 1722 Halford Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah V. Vansant

6 DATE OF BIRTH (month, day, and year) Mar 30 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	62	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chas. Stieff & Sons Balto Co Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Sarah V. Vansant

(Address) 1722 Harford Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 30, 1924.

that I last saw him alive on May 30, 1924,

and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) — yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) Endocarditis +

Myocarditis (duration) 4 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Donald H. Ebercrombie, M. D.

May 30, 1924 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Cem. Balto Co. DATE OF BURIAL June 2 1924

20 UNDERTAKER Wm Fickus & Sons ADDRESS June 2 1924

MAY 31 1924

Burial Permit Clerk

A.—THIS IS A PERMANENT RECORD. Every question must be answered. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87453

CERTIFICATE OF DEATH.

3 D 87453

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2438 Buchanan ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Nash

(Residence in Baltimore: No. 2438 Buchanan St.; 12 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word.)
Male	C.	Married

6-DATE OF BIRTH, Oct 10 (Month), ... (Day), 1854 (Year)

7-AGE, 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer Odd

9-BIRTHPLACE, (State or Country), Calvert Co Md

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER Mary Stewart

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ruth Nash

(Address) 2438 Buchanan

15-

Filed ..... Robert P. Harrison .....
Registrar.

MAY 31 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 29 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 1923, to May 29 1924, that I saw him alive on May 29 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis
Left Lung

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) C. K. Galonsky M. D.

May 29, 1924 (Address) 2413 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Leakin Manor Md	May 31, 1924

20-UNDERTAKER Wm R. G. Elliott ADDRESS Baltimore

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87454

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE (No. 718 Stockholm St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carroll

(a) Residence No. 718 Stockholm St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
m.	W.	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 1924

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or 6 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William E. Carroll

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Annapolis Md

12-MAIDEN NAME OF MOTHER, Emma Mary Weese

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Jackson Mich

14-

(Informant)..... Emma Carroll

(Address)..... 718 Stockholm

15-

Filed ..... Robert P. Harrison, Registrar.

Burial permit issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 28. 1924

17- I HEREBY CERTIFY, That I attended deceased from Did not attend 19.... to 19....

that I last saw h... alive on ..... 19....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. F. Engelhardt M. D

, 19 (Address) Isaac H. Hoffman 1013 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
JOHNS HOPKINS HOSPITAL	..... 19....
20-UNDERTAKER,	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WY3 T1924

Spec.—1-10-21—M&T—1500 Bks.

(Inman)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87455

CERTIFICATE OF DEATH.

74 D 87455

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 1647 E. 25th ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella Mae Inman

(a) RESIDENCE NO. 1647 E. 25th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bryon H. Inman.

6 DATE OF BIRTH (month, day, and year) July 15-1894

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
29.	10.	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER J. Steen Worrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Sulphin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Bryon H. Inman (Address) 1647 E. 25th

15 FILED MAY 31 1924 Albert E. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1924, to May 31, 1924, that I last saw her alive on May 31, 1924, and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Culbreth M.D.

, 19 (Address) 1192 W. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Airy North Carolina	6/2 1924
20 UNDERTAKER J. Frew McCully	ADDRESS 130 E Fort

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87456

CERTIFICATE OF DEATH.

164 D 87456

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 7605 E. Oliver St. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Julia Cacaor.

(a) Residence No. 7605 E. Oliver St. St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Cacaor

6-DATE OF BIRTH (month, day and year) Nov. 18-1854

7-AGE.	If LESS than 1 day,
69 yrs. 6 mos. 11 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Italy

PARENTS.

10-NAME OF FATHER. John Massa

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Italy.

14- (Informant) Mary Frankenberger

(Address) 7605 E. Oliver St.

15- 19.....

Registrar.

MAY 31 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29-1924

17- I HEREBY CERTIFY, That I attended deceased from April 12 1924 to May 29 1924

that I last saw h.. alive on May 23 1924

and that death occurred, on the date stated above, at 12.45 P. M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. L. McKinney M. D.

May 30. 1924 (Address) 224 E. 39

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	June 2 1924
20-UNDERTAKER.	**ADDRESS**
Lilly & Feeley	403 S. Wolfe

N. B.—WHITE PEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87457

CERTIFICATE OF DEATH.

D 87457

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2903 Tait ave. St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Weisenborn

(a) Residence No. 2903 Tait ave. St., 1 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 31st 1905

7-AGE. 18 yrs. 4 mos. 29 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Justus Weisenborn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Mary T. Lindner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14-

(Informant) Justus Weisenborn

(Address) 2903 Tait ave.

15-

Filed MAY 3 1924 Richard P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 29-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec-15 19 23 to May 29- 19 24

that I last saw h— alive on May 29 19 24

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. – ds.

CONTRIBUTORY (Secondary) General Thanatosis

(Sepsis) (Duration) yrs. D mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Jno. O'Bruen M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL, June 2nd 19 24

20-UNDERTAKER, Lilly & Zeibel

ADDRESS 403 S. Wolfe St

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important—See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D 87458

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-09

D 87458

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2720 Elliott St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Jabczynski

(a) Residence No. 2720 Elliott St., 1 Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Stanislawa Jabczynski

6-DATE OF BIRTH (month, day and year): Unknown

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland.

PARENTS.

10-NAME OF FATHER: John Jabczynski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Eva

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-

(Informant) Suzanna Beregne

(Address) 2720 Elliott St.

15-

Filed MAY 31 1924, 192.. Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 31/24

17- I HEREBY CERTIFY, That I attended deceased from May 23, 1924 to June 1, 1924

that I last saw him alive on May 29, 1924

and that death occurred, on the date stated above, at 3.40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

Secondary to Pyelonephritis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelonephritis Chronic

Duration yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Samuel F. Duckett M. D.

, 192 (Address) 832 S. Patterson

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 3rd 1924
20-UNDERTAKER, Lilly & Geiler	ADDRESS 403 S. Wood St

MAY 31 1924

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Niemaber

D 87459

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87459

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Niemaber

(a) RESIDENCE No. Mercy Hospital ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE: 65 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Matron

(c) Name of employer Mercy Hospi

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER J. B. Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kath. Kuhlemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Record

15 JUN 1 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/1924

17

I HEREBY CERTIFY, That I attended deceased from 5-29-24, 19, to 5-31-24, 19,

that I last saw her alive on 5-31-24, 19,

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

Arteio-Sclerosis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. W. Kelly, M. D.

, 19 (Address) Mercy Hk.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cincinnati Ohio — DATE OF BURIAL: 6/3/24

20 UNDERTAKER: George A Finley Fulton & Lynch — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Blks.

Sohn.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87460

CERTIFICATE OF DEATH.

47 D 87460

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2103 E. Fairmont Ave. St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bessie Sohin

(a) Residence No. 2103 E. Fairmont ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Sohin

6-DATE OF BIRTH (month, day and year) ?

7-AGE 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Russia

PARENTS.

10-NAME OF FATHER. A. Frank.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Shana Frank

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14-(Informant) Samuel Sohin

(Address) 2103 E. Fairmont Ave.

Filed JUN 1 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5/31/24

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1923 to May 31, 1924

that I last saw h.er alive on May 15, 1924

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Breast Carcinoma - Left Breast

(Duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Lungs

Mediastinum (Duration) X yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1923

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Sections

(Signed) L. Clarence Cohn M. D

5/31, 1924 (Address) 1829 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Sinai - Herman Hill Rd.	6-1-1924

20-UNDERTAKER Jack Levin ADDRESS 1499 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87461

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. D 87461

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 451 E. 22 ST. 9 WARD)

2-FULL NAME Mrs Ellen Pendergast

(a) RESIDENCE NO. 1924 Kennedy ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick J. Pendergast

6 DATE OF BIRTH (month, day, and year) Sept 8th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia

PARENTS

10 NAME OF FATHER John Brennan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Virginia

14 Informant Patrick Pendergast
(Address) 1924 Kennedy Ave

15 JUN 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis
Disease of Heart
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

(Signed) John H. Boerner M. D.
(Coroner.)
May 29, 1924 (Address) 1692 Rolandale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 1 1924
20 UNDERTAKER E. A. Wingfield Jr.	ADDRESS 501 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87462

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56 D 87462

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1219 W. Washington ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Wright

(a) RESIDENCE NO. 1219 W. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Garry S. Wright

6 DATE OF BIRTH (month, day, and year) Jan 2 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md

12 MAIDEN NAME OF MOTHER Mary Monroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Wright (Address) 1219 W Washington St

15 Filed JUN 1 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 19 24

17

I HEREBY CERTIFY, That I attended deceased from April 11, 19 24, to May 30th 19 24

that I last saw h alive on May 30th 19 24

and that death occurred, on the date stated above, at 2.40 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

Contributory Hypostasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Klotz, M. D.

May 31, 19 24 (Address) 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 2 1924

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87463

CERTIFICATE OF DEATH.

D 87463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 W. Conway st ST., 22 WARD)

2-FULL NAME Mrs Abel-

(a) RESIDENCE NO 626 W. Conway st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha E. Abel

6 DATE OF BIRTH (month, day, and year) May 8th, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	0	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Abel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sophia Emmerick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Bertha E. Abel
(Address) 626 Conway st

15 Filed JUN 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangled on food at Table

(duration) a few minutes ds.

CONTRIBUTORY (Secondary) Accident

(duration) yrs. mos. ds.

(Signed) H K Gorsuch, M. D.
(Coroner.)

5-31, 1924 (Address) 1171 W. Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 2nd 1924
20 UNDERTAKER Schoeman's Son	ADDRESS 634 Lanvale

N.B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87464

CERTIFICATE OF DEATH.

139

D 87464

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Carrie Hamilton

(a) RESIDENCE NO. 512 W. Hamburg ST. Baltimore WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Hamilton

6 DATE OF BIRTH (month, day, and year) Oct 1-5 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 637

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER George Miller

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Schmitler

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Raymond Hamilton
(Address) Son

15 Filed JUN 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1924, to May 31, 1924, that I last saw her alive on May 31, 1924, and that death occurred, on the date stated above, at 8.45a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency and Post Operative Gastro Intestinal Dilatation.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fibromyoma of Uterus

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of May 26/24.

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) R. D. Tyler M. D.

. 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 3 1924
20 UNDERTAKER	ADDRESS 1039
C. Schlosser Son	Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 77 D 87465

CERTIFICATE OF DEATH.

31 D 87465

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelo Sofai

(a) RESIDENCE No. 918 E Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5 1923

7 AGE — Years | 10 Months | — Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Camilla

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed JUN 1 - 1924 ROBERT R. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to May 31, 1924.

that I last saw him alive on May 31, 1924.

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R Bagg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Hospital — DATE OF BURIAL: June 2 1924

20 UNDERTAKER: Wm Cook — ADDRESS: Sorrento

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D 87466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87466

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 606 E. 37th St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Philip Lang

(a) Residence No. 606 E 37th St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Grace N

6-DATE OF BIRTH (month, day and year) April 15 1883

7-AGE. 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) Crown Cork & Seal Co

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bath

PARENTS.

10-NAME OF FATHER, Jacob Lang.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Annie Farber

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs. Grace N. Lang

(Address) 606 E 37th St

15- Filed JUN 1 1924 ROBT. R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 30 1924

17- I HEREBY CERTIFY, That I attended deceased from May 23 1924 to May 30 1924

that I last saw him alive on May 30 1924

and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D

5/30/1924 (Address) 2458 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn | DATE OF BURIAL. June 2 1924

20-UNDERTAKER. Wm Cook | ADDRESS 502 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Dr Leidner 15 01 Eager St Hope 0009

D 87467

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D 87467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1805 Aiken St., 9 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dorothea E Behling

(a) Residence No. 1805 Aiken St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Albert O Behling

6-DATE OF BIRTH (month, day and year) Mar 1. 1852

7-AGE. 72 yrs. 2 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Sophia L Sohfler
(Address) 1805 Aiken St

15- JUN 1 - 1924
Filed ..... 19.. ROBERT K. KRAUSE Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 30. 1924

17- I HEREBY CERTIFY, That I attended deceased from May 21st 19 24, to May 30 19 24, that I last saw h.. alive on May 29th 19 24, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Senile Debility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) O Stoner, M. D.

June 1st, 19 24 (Address) 1805 E Eager St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Schmuck — DATE OF BURIAL, June 2, 1924

20-UNDERTAKER, Wm Cook — ADDRESS 502 E North Ave

U. S. WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87468 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 S. Decker Ave. ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Hughes

(a) RESIDENCE NO. 511 S. Decker Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hughes

6 DATE OF BIRTH (month, day, and year) Sept. 13-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Canton Balto., Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER David Samuels

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wales

12 MAIDEN NAME OF MOTHER Mary Leyshon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wales

14 Informant Georges Hughes

(Address) 511 S. Decker Ave.

JUN 1 - 1924

Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to 5/30, 1924, that I last saw h[illegible] alive on 5/30, 1924, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. A. Reifschneider, M. D.

5/31, 1924 (Address) 2139 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL June 2, 1924

20 UNDERTAKER Fordeler & Parker — ADDRESS 739 E. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87469

CERTIFICATE OF DEATH.

57 D 87469

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 506 N. Madeira ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Gregor

(a) RESIDENCE NO. 506 N. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Gregor

6 DATE OF BIRTH (month, day, and year) April 12 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bohemia Europe

PARENTS

10 NAME OF FATHER Josef Svoboda

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia Europe

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia Europe

14 Informant (Address) John Cuka 506 N. Madeira St

15 Filed JUN 1 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17

I HEREBY CERTIFY, That I attended deceased from April 26, 1924 to May 31, 1924

that I last saw h[illegible] alive on May 31, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus following Gangrene of foot. about

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Slyzewski, M. D.

(Address) 814 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 3 1924
UNDERTAKER Zeller & Zeller	ADDRESS 239 Fagan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87470

CERTIFICATE OF DEATH.

100-001 D 87470

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Byrd ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul J. Zapkins

(a) RESIDENCE NO. 1812 Byrd ST., 24 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	1	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER August Zapkins

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Cowdly

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs M. Zapkins
(Address) 1812 Byrd St.

15 Filed JUN 1 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1924, to May 29, 1924, that I last saw h[illegible] alive on May 29, 1924 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Primary
(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Convulsions
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

May 29 1924 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL June 2 1924

20 UNDERTAKER Margaret L. Flynn ADDRESS 1427 Wright St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 87471

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 38 D 87471

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat St. 25th Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry W. Zramer

(a) RESIDENCE NO. Mt. Hope Retreat St., 25th Ward Columbia Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Zramer

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	59	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Drugs - 125

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Columbia Pa -

PARENTS

10 NAME OF FATHER Jos - H. Zramer

11 BIRTHPLACE OF FATHER (city or town) Lancaster (State or country) Pa

12 MAIDEN NAME OF MOTHER (?) Wisler

13 BIRTHPLACE OF MOTHER (city or town) Lancaster Co (State or country) Pa

14 Informant Records of Mt Hope Retreat (Address) Montrose Md

15 Filed JUN 1 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct 9th, 1923, to June 1, 1924, that I last saw him alive on May 31st, 1924, and that death occurred, on the date stated above, at 1. a. m.

The CAUSE OF DEATH* was as follows:

Paresis. (Luetic)

abt (duration) 2 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Paretic Psychosis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? (?) Columbia Pa.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia - Penna

DATE OF BURIAL June 1 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87472

CERTIFICATE OF DEATH.

90 D 87472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 550 Hanover St. ST., 7 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Smith.

(a) RESIDENCE NO. 550 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Smith

6 DATE OF BIRTH (month, day, and year) about 1880

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or .....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jos. W. Smith
(Address) 550 Hanover St.

15 Filed JUN 1 - 1924 HUBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy, M. D.
(Coroner.)
May 30, 1924 (Address) 1 Fredericksburg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-1 1924
20 UNDERTAKER Daniel Easton	ADDRESS 916 E Fay

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87473

CERTIFICATE OF DEATH.

11 VD 87473

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 W. Mulberry ST., 18 WARD)

2-FULL NAME Minnie F. Valenzia

(a) RESIDENCE NO. 1116 W. Mulberry ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daniel Valenzia

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Theodore Fertitta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Nancy Lacola
(Address) 1116 W. Mulberry St

15 Filed JUN 1 - 1924, 192.. Burial Permit Clerk.
ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) 2 hours.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. P. Norton, M. D.
(Coroner)

May 31st, 1924 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 6-2 1924

20 UNDERTAKER David Easton — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87474

CERTIFICATE OF DEATH.

100-001

D 87474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 244 N. Schroeder ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Hozey

(a) RESIDENCE. NO. 244 N. Schroeder ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie B. Hozey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cumberland Coal Co

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Robert Hozey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Cat Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Lillie Hozey

(Address) 244 N. Schroeder

JUN 2 - 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924 to May 30, 1924, that I last saw h.. alive on May 29, 1924, and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs and symptoms

(Signed) John C. C. Camper M. D.

, 19 (Address) 1405 Belmont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 3 19
20 UNDERTAKER John W. Toadvine	ADDRESS 142 Ursiel St

N. B.—WRITE PLAINLY, WITH UNFADING INK ...rm of information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... PHYSICIANS should ... that it may be ... Exact statement of OCCUPA... ...s on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87475

CERTIFICATE OF DEATH.

90 D 87475

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital St.: 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kastel (or Kazdalewicz)

(a) RESIDENCE. No. 226 S. Greene St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Joseph Kastel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Helen Michuls

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Reno
(Address)

15 JUN 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1924, to 5-31, 1924

that I last saw him alive on 5-30, 1924,

and that death occurred, on the date stated above, at 4 12 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic myocarditis
Myocardial insufficiency
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sat.

(Signed) Claude G. Dean, M. D

5-31 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 3, 1924
20 UNDERTAKER	**ADDRESS**
John Grebliauskas	425 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

Harry H. De Baer

D 87476

HEALTH DEPARTMENT—CITY OF BALTIMORE

167-001

D 87476

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1404 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry H. De Baer

(Residence in Baltimore: No. 1404 Poplar Grove St.; yrs., 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, August 11th, 1873
(Month) (Day) (Year)

7-AGE, 50 yrs. 9 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Jeweler
(b) General natnre of Industry, business, or establishment in which employed (or employer): (self)

9-BIRTHPLACE, (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER, Jacob De Baer

11-BIRTHPLACE OF FATHER, (State or Country), Holland

12-MAIDEN NAME OF MOTHER, Emma Cohen

13-BIRTHPLACE OF MOTHER, (State or Country), Hamburg, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jennie De Baer

(Address) 1404 Poplar Grove St.

15 JUN 2 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30th, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by asphyxiation (Illuminating Gas).

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

5-31, 1924 (Address) 2402 Edmondson Ave.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal**.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	June 2nd 1924
20-UNDERTAKER.	ADDRESS
Jos. B. Cook	1003 E. Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D 87477

CERTIFICATE OF DEATH.

D 87477

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 600 Linnard Street ST., 16 WARD)

2-FULL NAME Elizabeth Sands

(a) RESIDENCE No. 600 Linnard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of L. G. T. Sands

6 DATE OF BIRTH (month, day, and year) May 11 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER Richard Hardesty

11 BIRTHPLACE OF FATHER (city or town) Richmond
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Lenore C. Gray
(Address) 600 Linnard Avenue

15 Filed JUN 2 - 1926 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1926

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1926, to May 31, 1926, that I last saw h[illegible] alive on May 30, 1926 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Abt 3 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Duvall, M. D.

5-31-26 (Address) 1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Louis Cem Annapolis — DATE OF BURIAL June 2 1926

20 UNDERTAKER Joseph L. Cook — ADDRESS 1003 N Fulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87478

CERTIFICATE OF DEATH.

74 D 87478

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument st., 2 WARD)

2-FULL NAME Abraham Perel

(a) RESIDENCE NO. 806 E. Balto. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	m	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jania Perel

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jewelry 038

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Alexander Perel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jannie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Balto.

15 Filed JUN 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 31 1924

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1924, to May - 31, 1924,

that I last saw him alive on May - 31, 1924,

and that death occurred, on the date stated above, at 9.45 a -m.

The CAUSE OF DEATH* was as follows:

Embolus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ① Cancer of urinary bladder. ② Hypertrophy of prostate. ③ Myocarditis. ④ Thrombosis of abdominal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May-31-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Sophie A. Cohen M. D.

5/31, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Sanitarium Cem

DATE OF BURIAL 6/2 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Spec—12-23-21—E.B.R.S.—400 Bks.

87479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

36-004

D 87479

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 Homestead St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Cummings

(a) Residence No. 1701 Homestead St., Ward

(Usual place of abode)

(If non-residents, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Cummings

6-DATE OF BIRTH (month, day and year): June 8 -1890

7-AGE: 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Grocery

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Crew Va.

PARENTS:

10-NAME OF FATHER: Harry Cummings

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Yudas ----

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14-

(Informant): J. Leiws

(Address): 1439 E. Balto.

15-

Filed JUN 2 - 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 1-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 10, 19 24 to June 1, 19 24

that I last saw h.. alive on May 31, 19 24

and that death occurred, on the date stated above, at 5.30A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of left Kidney

about 2 mos. — ds.

(Duration)

CONTRIBUTORY (Secondary): Uremia

(Duration) yrs. mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Finding Tubercle Bacilli in pus from Left Kidney

(Signed) Theo H. Morrison M. D.

. 19 (Address) 1013 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. View Cemetery	June 2 19 24
20-UNDERTAKER.	ADDRESS
Jos. Lewis	1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87480

CERTIFICATE OF DEATH.

90 D 87480

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 McElderry St. ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Courtney

(a) RESIDENCE NO. 1602 McElderry St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred LIFE mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Courtney

6 DATE OF BIRTH (month, day, and year) Mch. 7th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER G. W. Hotten

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Harry Pead (Address) 1602 McElderry St.

15 JUN 2 - 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1924

17 I HEREBY CERTIFY, That I attended deceased from Dibey, 1924, to May 24, 1924, that I last saw h.. alive on May 24, 1924, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alb A Bugh, M. D.

6/7/24 (Address) 704 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jun. 3rd 1924
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec. 1-10-21 M&T 1500 Bks.

D 87481 HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D 87481

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenspring Ave Mt Washington ST., 27 WARD)

2-FULL NAME Ida R Bentley

(a) RESIDENCE No. Greenspring Ave Mt Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookfolder

(b) General nature of industry, business, or establishment in which employed (or employer) 064

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER T Lomas Bentley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Martha Power

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Maurice R Porter
(Address) Greenspring ave Mt Washington

15 Filed JUN 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30" 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1st, 1923, to May 30th, 1924, that I last saw h[illegible] alive on May 29th, 1924, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of right antrum,

abscess Duration one yr. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? X Ray & gen. symptoms

(Signed) O. H. Hoffman M. D.

5/31, 1924 (Address) 3404 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 2 1924
20 UNDERTAKER George J Smith	ADDRESS 1537 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87482

CERTIFICATE OF DEATH.

D 87482

Registered No. 46

1-PLACE OF DEATH

City of BALTIMORE: (No. 2427 Harlem Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Knell

(a) Residence No. 2427 Harlem Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, White

~~5-Single~~ Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Knell

6-DATE OF BIRTH (month, day and year) Nov. 27, 1871

7-AGE, 52 yrs. 6 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Geo. W. Bowen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Charlotte Wilkes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) John L. Knell

(Address) 2427 Harlem Ave

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar

JUN 2 - 1924

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1923, to June 1, 1924, that I last saw her alive on May 1, 1924, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Uterus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma (Implant of)

(Duration) yrs. 8 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 8-1923

Was there an autopsy? no

What test confirmed diagnosis Metastases at Operation

(Signed) Thos. H. Kelly M. D.

, 19 (Address) 2300 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount — DATE OF BURIAL, June 4 1924

20-UNDERTAKER, Geo. J. Smith — ADDRESS 1522 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87483

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Charles and 31st St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Grady

(a) Residence No. Homewood Apts St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Ellen Godfrey Grady

6-DATE OF BIRTH (month, day and year) Nov 28 1850

7-AGE, 73 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Dentist 055

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, James Grady

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Hand

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Ellen C Grady

(Address) Homewood Apts

15- ROBERT R. KRAUTER, Registrar.

JUN 2 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 21 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan. 15 19 24 to May 30 19 24

that I last saw h.. alive on May 29 19 24

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Chr. Brights Disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Harry L. Wilson M. D.

, 19 (Address) 13 W. Biddle St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL, June 2 19 24

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87484

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 D 87484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Argyle Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Johnson

(a) RESIDENCE NO. 924 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Johnson

6 DATE OF BIRTH (month, day, and year) about 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 04
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Helen Carter (Address) 924 Argyle Ave

15 JUN 2 - 1924 ROBERT H. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy M. D.
(Coroner.)

May 31. 1924 (Address) 28 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 2 1924
20 UNDERTAKER Mac R. C. Elliott	ADDRESS 25 E. Lanvale

INFORMATION IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87485 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 87485

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 Milliman St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Inez Maddox

(a) Residence No. 1603 Milliman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day,
....yrs. 2 mos. 6 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none 000

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto
(State or Country).

PARENTS.

10-NAME OF FATHER, Robert Maddox

11-BIRTHPLACE OF FATHER (city or town) Balto
(State or Country).

12-MAIDEN NAME OF MOTHER, Mary B Wesley

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country).

14-

(Informant) Mary B Wesley

(Address) 1603 Milliman St

15-

JUN 2 - 1924

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1 - 24

17- I HEREBY CERTIFY, That I attended deceased from March 25 1924 to May 31 1924

that I last saw h. alive on May 31 1924

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Debility on part of mother

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

6-1 1924 (Address) 1612 E Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Loudon Cemetery	June 3 1924
20-UNDERTAKER.	ADDRESS
Mrs R A Elliott	1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D 87486

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 908 Sterling St ..... St., 10 ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sheridon Robinson

(a) Residence No. 908 Sterling ..... St., ... Ward. Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, C.

5-Single, Married, Widowed, Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1879

7-AGE, 45 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Saloon 040

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Va

PARENTS

10-NAME OF FATHER, Joseph Robinson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Va

12-MAIDEN NAME OF MOTHER, Susan Robinson

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va.

11- (Informant) Susan Robinson

(Address) 908 Sterling st

15- JUN 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29-1924

17- I HEREBY CERTIFY, That I attended deceased from May 3 1924 to May 29 1924 that I last saw him alive on May 29 1924 and that death occurred, on the date stated above, at 9 A. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 3 mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Mell Kennard M. D

5-29. 1924 (Address) 708 Enson St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Eastern Cemetery DATE OF BURIAL. June 2. 1924

20-UNDERTAKER, Mrs. R. G. Allick ADDRESS 1720 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11

40 D 87487

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Royal Apts St., X Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Henry Foss

(Residence in Baltimore: No. Mt Royal Apts St.; yrs. 58 mos. 7 ds. 20)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH October 11 1865
(Month) (Day) (Year)

7-AGE. 58 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance Adjstr.
(b) General nature of industry, business, or establishment in which employed (or employer): Geo. Gable Adj. Co.

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. John H. Foss

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Amelia Manger

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss Margaret Foss (daughter)
(Address) Calvert Court Apts. City

15- JUN 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH May 21 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blades M. D.
(Coroner)
5/31/24 1924 (Address) 1426 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 0 yrs. 6 mos. 7 ds. In the State 58 yrs. 7 mos. 20 ds.

Where was disease contracted, if not at place of death? Mt Royal Apts

Former or usual residence Mt Royal Apts

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, June 3 1924

20-UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21 M&T 1500 Blks.

D 87488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Winchester ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Pinder

(a) RESIDENCE No. 1513 Winchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Eloise Pinder

6 DATE OF BIRTH (month, day, and year) Sept 1st 70

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Masonry Work

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John H. Pinder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eloise Pinder

(Address) 1405 Winchester

15 JUN 2 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1924

17

I HEREBY CERTIFY, That I attended deceased from 5/30½, 1924, to 5/30, 1924,

that I last saw him alive on 5/30, 1924,

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Ca. hepatic + pleurisy

(duration) yrs. 4 mos 29 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6 mos ago

Was there an autopsy? no Removal of Leg

What test confirmed diagnosis?

(Signed) Ben R. Miller M. D.

5/31, 1924 (Address) 2 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL June 2 1924

20 UNDERTAKER Sam'l W. Grace & Son ADDRESS 1400 Pulaski

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87489

CERTIFICATE OF DEATH.

101-001

D 87489

1-PLACE OF DEATH

City of BALTIMORE: (No. 5226 Denmore Ave St., 27 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace V. Whiteley

(a) Residence No. 5226 Denmore Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 13. 1879

7-AGE. 45 yrs. 7 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto City

PARENTS.

10-NAME OF FATHER Chas A. Whiteley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto City

12-MAIDEN NAME OF MOTHER, Maria L. Meuse

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-

(Informant) Mrs. C. A. Whiteley

(Address) 5226 Denmore Ave

15-

Filed JUN 2 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 31/24

17- I HEREBY CERTIFY, That I attended deceased from May 24, 19 24 to May 31, 19 24

that I last saw h.r alive on May 31

and that death occurred, on the date stated above, at 3.0 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Grippe

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of May 31

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) W. D. Wells M. D.

, 19 (Address) 32 W Cold Spring Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem

DATE OF BURIAL June 3rd 19 24

20-UNDERTAKER. Geo. M. Fenhagen & Son

ADDRESS 811 W Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87490

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87490

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S. Poppleton ST., 18 WARD)

2-FULL NAME Beulah Hoffman

(a) RESIDENCE NO. 310 S. Poppleton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George W Hoffman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Emma M Kunnecke

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Geo W. Hoffman
(Address) 310 S Poppleton st

JUN 2 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/21/, 1924, to 6/1/, 1924,

that I last saw h[illegible] alive on 6/1/24, 19

and that death occurred, on the date stated above, at 9 10 A. m.

The CAUSE OF DEATH* was as follows:

Measles

History (duration) about yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Tonsilitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard Myerberg, M. D.

6/1, 1924 (Address) 910 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 6-3 1924

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins sts

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Mary S. DeLat

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87491 D 87491

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2507 Druid Hill Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. de Lat

(a) Residence No. 2507 ~~Druid~~ Druid Hill Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Francis H. de Lat

6-DATE OF BIRTH (month, day and year) May 5 1875

7-AGE. 49 yrs. 0 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Co Md

PARENTS.

10-NAME OF FATHER, Frank Dobbin

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER, Elderkoon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Francis H. DeLat

(Address) 2507 Druid Hill

Filed JUN 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 1, 1924.

17- I HEREBY CERTIFY, That I attended deceased from October 15, 1923, to June 1st, 1924, that I last saw her alive on June 1st, 1924, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Adeno-carcinoma of left breast; (secondary carcinoma, right breast).

(Duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxemia and exhaustion.

(Duration) yrs. 1½ mos. ds.

18-Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? yes, Date of Sept. 1919.

Was there an autopsy? no

What test confirmed diagnosis? Microscopical.

(Signed) Chas. J. Robertson, M. D.

June 1, 1924 (Address) 22 Ailsa Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL. 6-3-, 1924

20-UNDERTAKER. Wm Cook — ADDRESS 502 E Nork St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87492

111 002

D 87492

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 7 WARD)

2-FULL NAME Mary Koller

(a) RESIDENCE NO. 916 E. Durham ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 19 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Koller

6 DATE OF BIRTH (month, day, and year) Aug 13 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Alexander Freeberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Fuschenbauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant James Wentzel Koller

(Address) 113 S Durham

15 Filed JUN 2 - 1924 19 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1924, to June 1, 1924.

that I last saw her alive on June 1, 1924

and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of May 31, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Isidor S. Fry, M. D.

June 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL June 4 1924

20 UNDERTAKER Wendell Dyffel & Son

ADDRESS 37 S Howard

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87493

CERTIFICATE OF DEATH.

X 49

D 87493

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hosp. St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archibald Alby

(a) Residence No. Bryantown, Chas. Co. Md St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	W.	Unknown

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
62 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Store

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), " "

14- (Informant) J. C. Alby

(Address) 3308 Harford Rd

15- JUN 2 - 1924 ROBERT R. KRAUSER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-1-1924

17- I HEREBY CERTIFY, That I attended deceased from March 29- 1924 to 6-1 1924

that I last saw him alive on 6-1 1924

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Cachexia
Carcinoma of the Penis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Yes - 1920?

Did an operation precede death? No Date of

Was there an autopsy? Phys. Exam.

What test confirmed diagnosis?

(Signed) Holland per [illegible] M. D.

19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St Marys Co Bros. Ems. Mechanicsville Md	6-2, 1924
20-UNDERTAKER.	ADDRESS
E & B Harle	115 E Mosher St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87494

CERTIFICATE OF DEATH.

91-002 D 87494

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1433 Banks ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas H Winkler

(a) RESIDENCE No 1433 Banks ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E. Winkler

6 DATE OF BIRTH (month, day, and year) June 5 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	70	11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Cooper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ky.
(State or country)

PARENTS

10 NAME OF FATHER Shallis Winkler

11 BIRTHPLACE OF FATHER (city or town) Ky
(State or country)

12 MAIDEN NAME OF MOTHER Hutchcomb

13 BIRTHPLACE OF MOTHER (city or town) Ky
(State or country)

14 Informant Wife Comp. Lt. Patrick
(Address) 3305 East Pratt St. Canton

15 Filed JUN 2 - 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Res death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Jos Clinton Blades, M. D.
(Coroner.)

5/31/24, 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL June 3 192

20 UNDERTAKER George L Schwab ADDRESS 1101 Fulton Ave

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87495

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D 87495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1611 Park Ave St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Joseph Hogan Jr.

(a) Residence No. 1611 Park Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, Divorced. (Write the word.) ~~Married~~ Widowed

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Birdie Bayless Hogan

6-DATE OF BIRTH (month, day and year) Oct. 14, 1853

7-AGE. 71 yrs. 7 mos. 17 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Merchant
(b) General nature of industry, business, or establishment in which employed (or employer). Dry Goods
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Tuscaloosa, Ala.

PARENTS.
10-NAME OF FATHER. Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown
12-MAIDEN NAME OF MOTHER. Katherine Ryan
13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) William J. Hogan
(Address) 1611 Park Ave

Filed JUN 2 - 1924 192.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 31-1924

17- I HEREBY CERTIFY, That I attended deceased from May 9, 1924, to May 31, 1924
that I last saw him alive on May 31, 1924
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McCleary M. D.
. 19 (Address) 1609 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	June 3, 1924
20-UNDERTAKER.	ADDRESS
M. Fahey Sons.	827 W North

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87496

CERTIFICATE OF DEATH.

100-001 ✓

D 87496

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rufus Armstrong

(a) Residence No. 1232 Druid Hill ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, (Married) Widowed, or Divorced, (Write the word.)
Male	Black	Married

5a-If married, Widowed, or divorced (HUSBAND of) (or) WIFE of Lizzie Armstrong

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter 070

(b) General nature of Industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9-BIRTHPLACE (city or town) (State or Country). N. C.

PARENTS.

10-NAME OF FATHER, William Armstrong

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N. C.

12-MAIDEN NAME OF MOTHER, Lydia Ellis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N. C.

14- (Informant) Bayview Hospital

(Address) Balto Md.

15- Filed JUN 2 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5/31/24

17- I HEREBY CERTIFY, That I attended deceased from 4/10 1924 to 5/31 1924

that I last saw him alive on 5/31 1924

and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Terminal (bronchopneumonia)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

5/31 (Signed) N. Edmunds M. D.

1924 (Address) Bayview Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va DATE OF BURIAL June 2 1924

UNDERTAKER Frederick Bloodsworth ADDRESS 1317 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-21—M&T—100 Bks.

D 87497

HEALTH DEPARTMENT—CITY OF BALTIMORE

1886 D 87497

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9th & O'donnell ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Coats

(a) RESIDENCE NO 3807 Benefit ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Barrows
(State or country) Green County Ill.

PARENTS

10 NAME OF FATHER Wm Coats

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ill.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ill.

14 Informant Katie Webster
(Address) 3807 Benefit St.

15 Filed JUN 2 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
R.R. Accident

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo Elliott Blades M. D.

(Coroner) 6/2/24 192 (Address) 143 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roadhouse Ill.

DATE OF BURIAL 6/2 1924

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec–12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87498

D 87498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Fred Dill

(a) Residence No. Rose Ave Catonsville St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Dill

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Plasterer

(b) General nature of Industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Wife.

(Address) Catonsville Md.

Filed JUN 2 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 27 19 24 to June 1 19 24

that I last saw h[illegible] alive on June 1st 19 24

and that death occurred, on the date stated above, at 9P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) ? yrs. mos. ds.

CONTRIBUTORY Prostatic Hypertrophy.

(Secondary)

(Duration) ? yrs. mos. ds.

18-Where was disease contracted if not at place of death? Md.

Did an operation precede death? No Date of

Was there an autopsy? No Exam.

What test confirmed diagnosis? Phys. Exam.

(Signed) H W Harper M. D.

, 19 (Address) St Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Salem Lutheran Cem. DATE OF BURIAL. June 4, 1924

20-UNDERTAKER. Easton Sons & Elliott City ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87499

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87499

21

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Fifth Ave Regnel Hghts ST.: 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Weikel

(a) RESIDENCE. NO. 701 Fifth Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 13 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Clinton Edward Weikel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Esther Greenwald

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs Esther L. Weikel
(Address) 701 5th Ave Regnel Heights

15 JUN 2 - 1924 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23rd, 1924, to June 1st, 1924, that I last saw her alive on May 31st, 1924, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardio-Respiratory Paralysis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Double Otitis Media Purulent, Infection face (erysipelas?) (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. W. V. Clift, M. D.

6/1, 1924 (Address) 1312 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 3 1924
20 UNDERTAKER Jos Joerdens & Son	ADDRESS 217 S. Pac.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87500

CERTIFICATE OF DEATH.

92 D 87500

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2426 Edmondson Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Scott

(a) Residence No. 2426 ~~Scott~~ Edmondson Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin PScott

6-DATE OF BIRTH (month, day and year) Oct. 17. 1866

7-AGE. 57 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Keeper

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md.

PARENTS.

10-NAME OF FATHER, John Hartman

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country) Md.

12-MAIDEN NAME OF MOTHER, Mary Williams

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country) Md.

14- (Informant) Benj. P. Scott

(Address) 2426 Edmondson Ave.

15- Filed Robert P. Harrison, Registrar.

GN2 - 1924 ~~1924~~ Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from May 5, 1924 to May 31 1924

that I last saw h alive on May 31, 1924

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Embolus 15 minutes

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 6, 1924

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jas. L. Lumpkin M. D

June 2 1924 (Address) 818 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL, June 4 1924

20-UNDERTAKER. Jos. J. Sudano Sons ADDRESS Gorsuch

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87501

CERTIFICATE OF DEATH.

101-001 ✓ D 87501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St., 2 2 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Glenn Bailey

(a) RESIDENCE NO. 5275 S. Green ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Bailey

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ryne

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Record
(Address)

15 Filed 6-12-24 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/24

17 I HEREBY CERTIFY, That I attended deceased from 5/23/24 to 6/11/24 19 .

that I last saw h~~e alive~~ on 6/11/24, 19 .

and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Dolley, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md.

DATE OF BURIAL 6-2 1924

20 UNDERTAKER E & B Hall

ADDRESS 115 E Main St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN2

MARGIN RESERVED FOR BINDING

NOTICE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state it for-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87502

CERTIFICATE OF DEATH.

90 D 87502

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore Md.

CITY OF BALTIMORE: (No. 2117 N. Charles St. ST., 17 WARD)

2-FULL NAME Mrs. Sarah Connery

(a) RESIDENCE NO. 2117 N. Charles St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) WIFE of Edmund Connery

6 DATE OF BIRTH (month, day, and year) Sept 26, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Michael Linan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Clara E. Connery (daughter)
(Address) 2117 N. Charles St

15 Filed JUN 2 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1924, to June 2, 1924.

that I last saw her alive on June 2, 1924.

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Wm J Watson, M. D.

June 3, 1924 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL ... 19

20 UNDERTAKER Henry H. Jenkins & Son

ADDRESS Mt Clifford & Orchard

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... may be important. See instructions on back of certificates.

JUN 2 - 1924

Spec.—1-10-21—M&T—1500 Blks.

D 87503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87503

CERTIFICATE OF DEATH.

117

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., 29 WARD)

2-FULL NAME Robert Poel Fang

(a) RESIDENCE NO. 370 Overlea ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 26 24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo Edward Fang

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Eidman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant G Edward Fang
(Address) 371 Overlea ave

15 Filed ..... 19 ..... Robert P. Harrison
Registrar

Burial Permit Gr.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to June 1, 1924
that I last saw him alive on June 1, 1924
and that death occurred, on the date stated above, at 8.15 P. m.
The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of May 28-24
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) James Hubert Wiseman M. D.
19 (Address) Md. General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Bcm

DATE OF BURIAL June 1924

20 UNDERTAKER W. M. Rontcon

ADDRESS 2238 N Monta

Spec–12-23-21–E.B.R.S.–400 Bks.

D 87504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87504

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Lahman

(a) Residence No. 2414 E. Biddle st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1906 March 20

7-AGE. 18 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Kent Co

(State or Country) Galena Maryland

PARENTS.

10-NAME OF FATHER. Chas. F. Lahman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Daisy D. Hall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed JUN 2 - 1924 19 Robert P. Garrison Registrar.

Mrd Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 13 19 24 to June 1 19 24

that I last saw him alive on June 1 19 24

and that death occurred, on the date stated above, at 10.45A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 4 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally M. D

6-2- , 19 24 Address Municipal Tbc. Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL. Galena Kent Co Md Ship to Bingley Md

DATE OF BURIAL, June 4 19 24

20-UNDERTAKER. George Schilling & Son

ADDRESS 1126 E Monument St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87505

D 87505

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Fayette and Payson ST., 20 WARD)

2-FULL NAME Daniel Sullivan

(a) RESIDENCE No. Bon Secours Convent ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener 886

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records
(Address)

15 JUN 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17

I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1923, to June 1, 1924.

that I last saw him alive on June 1, 1924,

and that death occurred, on the date stated above, at 10½ P. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency with cardiac dilatation and myocardial failure

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 5-0 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann +++

(Signed) Thos Powers, M. D.

6/2/1924 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/5/24
20 UNDERTAKER	ADDRESS
Engel & Sons Funeral	Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87506

CERTIFICATE OF DEATH.

X 38

D 87506

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp ST., 9 WARD)

2-FULL NAME Daniel Webster Kone

(a) RESIDENCE NO. Delight Ave. ST., Fullerton WARD Fullerton Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Iona Kone

6 DATE OF BIRTH (month, day, and year) Dec. 14th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U. S. A.

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel N. Kone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Nebraska

12 MAIDEN NAME OF MOTHER Sarah B. Fitch

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Iona Kone
(Address) Fullerton Md.

15 Filed ....., 19.... Robert P. Harrison, Registrar

Muriel Perott Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1924, to June 1, 1924.

that I last saw h~~is~~ alive on June 1, 1924

and that death occurred, on the date stated above, at 10 05 ~~p~~ a. m.

The CAUSE OF DEATH* was as follows:

Ruptured coronary artery

(duration) yrs. mos. hours ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Raspeburg Post Office

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo. B. Dyberth, M. D.

, 19 (Address) St Jos. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 3 1924
20 UNDERTAKER	ADDRESS
Fredk Lassahn Iona	Fullerton

JUN 2 1924

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Bodon

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28 1924

17 I HEREBY CERTIFY, That I attended deceased from 9-10, 1923, to 5-28, 1924, that I last saw him alive on 5-27, 1924, and that death occurred, on the date stated above, at 6:15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude L Howe, M. D.

5-28 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 6/2/24

20 UNDERTAKER J J Fahey Sons — ADDRESS 1218 Light St

Spec—12-23-21—F.B.R.S.—400 Bks.

D 87508 ✓ D 87508

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87508 101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3553 Sweetair St 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret R Shipley

(a) Residence No. 3553 Sweetair St Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-[illegible] Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joshua Shipley

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 68 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Mill Operator

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer. N/A

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Unknown

14-(Informant) Thomas L Shipley

(Address) 3553 Sweetair St

15-Filed JUN 2 - 1924 Registrar.

Reb't P. Harrison

Reid Ferrell Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 31 1924

17-I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to May 31, 1924, that I last saw h[illegible] alive on May 31, 1924, and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? St Agnes Hosp.

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

June 2, 1924 (Address) 865 W. 34th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Cem

DATE OF BURIAL. June 3, 1924

20-UNDERTAKER. GREENWETH & SON

ADDRESS 3017 CHESTNUT AVE

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupations TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87509

CERTIFICATE OF DEATH.

D 87509

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1212 St. Paul St ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William David Johnson

(a) RESIDENCE No. Snow Hill Md ST., WARD Snow Hill Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or WIFE of)~~ Sallie M Johnson

6 DATE OF BIRTH (month, day, and year) Nov 8, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Same

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Snowhill, Md

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Snowhill Md

12 MAIDEN NAME OF MOTHER Mary Scarborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Snowhill Md

14 Informant Mrs Mary Johnson (Address) 1212 St Paul St

15 Robert P. Harrison, M.D. Registrar

JUN 2 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1924, to June 2, 1924, that I last saw him alive on June 2, 1924, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate with metastases to pelvis & abdominal organs.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation & Cachexia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Snowhill, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray Symptoms.

(Signed) B A Fullerton, M. D.

(Address) 1527 Linden Ave, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Snow Hill Md

DATE OF BURIAL 6/3 1924

20 UNDERTAKER Robt Brooks & Son

ADDRESS —

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87510

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87510

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S Marine Hospital #1

CITY OF BALTIMORE: (No. Baltimore 2nd ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James B. Hall

(a) RESIDENCE NO. U.S. Marine Hosp #1 ST., WARD Alexandria Va.

(Usual place of abode)

Length of residence in city or town where death occurred Baltimore 2nd yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. A. J. Courtney

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Abt. 63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer U/S S.S. Ocean Disc

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Olivia Craske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address)

15 Filed JUN 2 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1924 to June 2, 1924, that I last saw him alive on June 2, 1924, and that death occurred, on the date stated above, at 4 P.m.

The CAUSE OF DEATH* was as follows:

Epithelioma, metastatic glands neck

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C. F. McDevitt, M. D.

, 19 (Address) U. S. Marine Hospital Baltimore 2nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Alexandria

DATE OF BURIAL 19

20 UNDERTAKER D F Whippert

ADDRESS 1126 Eighth Ave Balto Md

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87511

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87511

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH South Balt Gen Hosp.

CITY OF BALTIMORE: (No. 1213 Light St near West ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M Porter

(a) RESIDENCE No. 1028 Warden Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Porter

6 DATE OF BIRTH (month, day, and year): Aug-11-1854

7 AGE: Years 69 | Months 9 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): (Self)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Knoxville Md.

PARENTS

10 NAME OF FATHER: John Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll County Md.

12 MAIDEN NAME OF MOTHER: Mary Leatherwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll County Md

14 Informant: Chester O. Porter

(Address): 645 N. Kenwood Avenue

15 JUN 2 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/2 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/29, 1924, to 6/2/24, 19.

that I last saw him alive on 6/2/24, 19.

and that death occurred, on the date stated above, at 1.50 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6-2 1924 (Address) 1629 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: June 4 1924

20 UNDERTAKER: Joseph L. B. Cook — ADDRESS: 1303 E. Balto

Spec—12-23-21—E.B.R.S.—400 Blks. Mary L. Garrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87512 D 87512

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2105 Penrose St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary L. Garrison.....

(a) Residence No. 2105 Penrose St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Richard H. Smarden

6-DATE OF BIRTH (month, day and year) June 16, 1860

7-AGE,	If LESS than 1 day,
63 yrs. 11 mos. 17 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 60
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Montgomery County
(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER, William Chandlee

11-BIRTHPLACE OF FATHER (city or town)..... Montgomery
(State or Country)..... County, Maryland

12-MAIDEN NAME OF MOTHER, Martha E. Sutton

13-BIRTHPLACE OF MOTHER (city or town)..... Baltimore County
(State or Country)..... Maryland

14- (Informant)..... Richard Smarden
(Address)..... 2105 Pearose Avenue

15- Robert E. Garrison, Registrar.

Filed..... 192.....

JUN 2 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 13, 19.24 to June 2, 19.24
that I last saw him alive on June 2, 19.24
and that death occurred, on the date stated above, at 12.15 A m.
The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
from Pulmonary Tuberculosis
(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Walter B. Cook, M. D.

6-2, 1924 (Address) 54 S. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	June 4th, 1924
20-UNDERTAKER.	ADDRESS
Joseph B. Cook	1003 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2507 Guilford Ave St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice P. Towles

(a) Residence No. 2507 Guilford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Leagth of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced—HUSBAND of (or) WIFE of: Lydia E Towles

6-DATE OF BIRTH (month, day and year): June 30—1874

7-AGE. 52 yrs. 11 mos. 19 ds. If LESS than 1 day, hrs. or mio.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Fruits 166

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Lydia E Towles
(Address) 2507 Guilford Ave

15- Filed 192 Robert P. Harrison, Registrar.

JUN 2 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 1st 1924

17- I HEREBY CERTIFY, That I attended deceased from April 16th 1924 to June 1st 1924.

that I last saw him alive on May 31st 1924.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Primary Carcinoma of Liver

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) William J Kessick M. D

. 19 (Address) 1700 Linden ave.

*State the **Disease Causing Death**, or In deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md | DATE OF BURIAL, June 3 1924

20-UNDERTAKER: W. E. Richardson & Son | ADDRESS: Bath Ave

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87514

D 87514

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2638 Pennsylvania Ave 15 Ward) 21

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Roger Streett Whiteford

(a) Residence No. 2638 Pennsylvania Ave. Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Whiteford

6-DATE OF BIRTH (month, day and year) Apr 3, 1875

7-AGE. 49 yrs. 1 mos. 29 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Garage Owner

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Self

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Harford Co

(State or Country)..... Md.

PARENTS.

10-NAME OF FATHER, John S. Whiteford

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country)..... Md

12-MAIDEN NAME OF MOTHER, Ruth Streett

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country)..... Md.

14- (Informant) Mrs. Elizabeth Whiteford

(Address) 2638 Penna Ave.

15- Filed Jun 2 1924 Robert F. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1 1924

17- I HEREBY CERTIFY, That I attended deceased from May 26, 1924, to June 1, 1924, that I last saw h. im. alive on May 31, 1924, and that death occurred, on the date stated above, at 8.45a m.

The CAUSE OF DEATH* was as follows:

Examination suffocation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion from pain, vomiting & shock,

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bernard Good M. D

Jun 2, 1924 (Address) 626 N. Glenn St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem. DATE OF BURIAL. June 3. 1924

20-UNDERTAKER. Wm J Fichter & Sons ADDRESS North & Paine.

JUN 2 - 1924

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

✓ D 87515

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87515

CERTIFICATE OF DEATH.

90 Gardenville
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bowleys Lane & Fursley Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annah Frances Cassard

(a) RESIDENCE No. Bowleys Lane & Fursley Ave ST., Gardenville WARD
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 29 1842

7 AGE — Years: 82 — Months: 4 — Days: 2

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Gilbert Cassard

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary League

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Mrs Mary Cotton
(Address) Bowleys Lane & Fursley Ave

15 JUN 2 1924

16 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from May 30th 1924 to June 1st 1924, that I last saw h alive on May 30th 1924 and that death occurred, on the date stated above, at 6.30 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia Chronic Valvular Disease
(duration) yrs. mos.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W T Elder, M. D.

June 2 1924 Address 1501 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: May 1924

20 UNDERTAKER: Fred'k Lassahn & Son — ADDRESS: Fullerton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87516

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. E Hamilton Ave ST., Rayesbury WARD) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Burton

(a) RESIDENCE NO. E Hamilton Ave ST., Rayesbury WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 hours. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 2, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Raspeburg Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo W. Burton

11 BIRTHPLACE OF FATHER (city or town) Glenarm
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ledden

13 BIRTHPLACE OF MOTHER (city or town) Alloway
(State or country) New Jersey

14 Informant Mrs Geo Burton (Mother)
(Address) E Hamilton Ave

15 Filed JUN 2 - 1924, Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 2, 1924, that I last saw h.. alive on June 2, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6½ hours Duration)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward W Benson, M. D.

June 2 1924 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	June 3 1924
20 UNDERTAKER	ADDRESS
Fred'k Lessehorst Sons	Fullerton

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87517

CERTIFICATE OF DEATH.

118 D 87517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 22 St.; Children's Clinic. WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Brown

(Residence in Baltimore: No. 122 W. Hughes St., St.; ..... yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, ... (Month) ..... (Day) 1924 (Year)

7-AGE, ... yrs. 3 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Sutton Short

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Lucy Brown

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lucy Brown

(Address) 122 W. Hughes

15-FILED JUN 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1924, to June 2 1924, that I saw him alive on June 2 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Hypocardial Insufficiency
Adams Stokes
(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction. Strangulated Inguinal Hernia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Day Allen, M. D.

June 2, 1924 (Address) University Hospital Children's Clinic

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Ct — DATE OF BURIAL, June 4, 1924

20-UNDERTAKER S. W. Brown & Son — ADDRESS 108 N. Monroe

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87518 — 90 D 87518

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1019 Reach al (St.) 23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Carnish

(a) RESIDENCE NO. 1019 Reach al St. 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress out

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Henry Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Susan Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Grace Thomas (Address) 1019 Reach alley

15 Filed JUN 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/24/1924, to 5/31/1924

that I last saw her alive on 5/30/1924

and that death occurred, on the date stated above, at 2.10 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis duration Chronic yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) 908 Shark Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL June 3 1924

20 UNDERTAKER H. W. Brown & Son — ADDRESS 108 N. Mad

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D 87519
Registered No.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1048 Vine St., 18 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice T Butler

(a) Residence No. 1048 Vine St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem
4-COLOR OR RACE, Col
5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 46 yrs. mos. ds.
If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laundress
(b) General nature of Industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va.

PARENTS.
10-NAME OF FATHER, Unknown
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Alice Palmer
(Address) 420 N. Gilmor St

15- JUN 3 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1-1924

17- I HEREBY CERTIFY, That I attended deceased from Apl 18 24 to June 1, 19 24, that I last saw h alive on May 31, 19 24, and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
about 6 mos
(Duration) yrs. mos. ds.
CONTRIBUTORY Pulm. Oedema
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B.

(Signed) J. Norwood M. D.
June 2 19 24 (Address) 739 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL, June 3, 19 24

20-UNDERTAKER. John H. Toadvine — ADDRESS 142 Ostend St

N. B.—WRITE PLAINLY, WITH INDELIBLE LEAD OR BLACK WRITING INK—THIS IS A LEGAL DOCUMENT. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87520

CERTIFICATE OF DEATH.

31

D 87520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S Fremont ST. 21 WARD)

2-FULL NAME Ella Dawson

(a) RESIDENCE NO. 226 S Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Dawson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) " 37

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Sharp Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Geo Dawson (Address) 226 S Fremont

Filed JUN 3 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 4/5/ 24 to 5/31/ 24

that I last saw her alive on 5-30/ 24

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

Pulmonary Tbc /,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ,

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo Gurley M. D.

6/4 19 24 (Address) 1088 Hart St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. Auburn

DATE OF BURIAL June 3 1924

20 UNDERTAKER John H. Tradin

ADDRESS 1042 Hart St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

151 D 87521

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Eldorado Ave S. of Oakford Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lucinda Dorothea Fisher

(a) Residence No. Eldorado Ave S of Oakford Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Fisher

6-DATE OF BIRTH (month, day and year) Mar 13/1843

7-AGE,	If LESS than 1 day,
81 yrs. 2 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Germany

PARENTS.

10-NAME OF FATHER, Theodore Binder

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Germany

11- (Informant) Mrs A. M. Timmons

(Address) 1808 Fredericke Ave

JUN 3 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb-16 19.24 to June 2 19.24

that I last saw h.e alive on May 29 19.24

and that death occurred, on the date stated above, at 5-30a. m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene of Left Foot.

about 4 (Duration) mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) G. Lotsch Ewalt M. D.

6/2, 1924 (Address) 2945 St. Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
London Park Cemetery	June 4, 19.24
20-UNDERTAKER.	ADDRESS
Harry N Ormsby	4204 Ridgewood Ave

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—F.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87522

D 87522

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 709 Light St. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Emeline Berlin

(a) Residence No. 709 Light St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Roland Clinton Berlin

6-DATE OF BIRTH (month, day and year) June 7, 1873

7-AGE. 25 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Thomas Harrison

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Virginia Hollidge

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

11-Informant Roland C. Berlin

(Address) 709 Light St.

15-Filed JUN 3 - 1924 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2 24

17. I HEREBY CERTIFY, That I attended deceased from May 1 1924 to June 2 1924

that I last saw h. alive on June 1 1924

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. & L. Campbell M. D.

June 2 1924 (Address) 1644 Hanover St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge — DATE OF BURIAL. June 7 1924

20-UNDERTAKER. Wm Cook & Son — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 87523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10

D 87523

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 Wilkins Ave ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harold Williams

(Residence in Baltimore: No. 2119 Wilkins Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, or DIVORCED. (Write the word.)
M	W	Single

6-DATE OF BIRTH, April (Month) 26 (Day), 1924 (Year)

7-AGE. 3 yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Turner Williams

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Audrey Brown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Turner A Williams

(Address) 2119 Wilkins Ave

15- JUN 3 - 1924 191 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 2 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 31 1924, to June 2 1924, that I saw h[illegible] alive on June 2 1924, and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia Right

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Edward Vanderbeek M. D.

6/3/24 1924 (Address) 24 W Fulton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Harris Ville Va	6-4, 1924
REGISTERED NO.	ADDRESS Calhoun & Hollins

ROBERT BROOKS & SON
FUNERAL DIRECTORS & EMBALMERS
S. E. CORNER CALHOUN & HOLLINS STREETS.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87524 HEALTH DEPARTMENT—CITY OF BALTIMORE 162 D 87524

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 700 W. 34th St St., 13 Ward)

Registered No. 2349.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Vernon Reno Pal

(a) Residence No. 700 W. 34th St St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 30, 1924

7-AGE, — yrs. — mos. 3½ ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Roland Pal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Cockeysville Md.

12-MAIDEN NAME OF MOTHER, Martha Grimes

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Montgomery Co. Md.

14- (Informant) Roland Pal

(Address) 700 W. 34th St

15- Filed JUN 3 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 3, 1924.

17- I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to June 3, 1924, that I last saw him alive on June 2, 1924, and that death occurred, on the date stated above, at 4:30 A.m.

The CAUSE OF DEATH was as follows:

Congenital Atelectasis

(Duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Premature Birth

(Signed) Walter D. Healy M. D.

, 19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Woodlawn

DATE OF BURIAL, June 3, 1924

20-UNDERTAKER, CHENOWETH & SON,

ADDRESS 2017 CHESTNUT AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87525

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922-Washington Blvd ST., 21 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Edward Smith

(a) RESIDENCE NO. 922-Washington Blvd ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 6 ds. How long in U. S., if of foreign birth? — yrs. — mos. 6 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-28-1924.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) 922-Washington Blvd. Baltimore, Md.

PARENTS

10 NAME OF FATHER Elmer Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Lillian Gresham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Mother Lillian Smith (Address) same 922 Wash Blvd

15 Filed JUN 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3-1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to June 3, 1924, that I last saw him alive on June 3, 1924, and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage. (6 hrs.).

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemaphlia - prolonged Labor (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 2/24.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Bowie, M. D.

, 19 (Address) 904-N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 4 19 24

20 UNDERTAKER John J. Fields ADDRESS 1200 W. Fayette

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87526

CERTIFICATE OF DEATH.

D 87526

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [redacted] St.: 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Wain

(a) RESIDENCE. No. 2037 Hollins St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hatter

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Wain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hattie Connie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Geo H Wain Jr

(Address) 2037 Hollins St

15 Filed JUN 3 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 19 24

17

I HEREBY CERTIFY, That I attended deceased from April 1, 19 24, to June 1— , 19 24, that I last saw him alive on June 1— , 19 24, and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Suppurated Gall Bladder

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) Estelle Henning, M. D.

6/2, 19 24 (Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Jun 5 19 24

20 UNDERTAKER John J Feldt ADDRESS 1200 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87527

CERTIFICATE OF DEATH.

D 87527

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 E. Chase ST., 8 WARD)

2-FULL NAME Allen E. Southcomb

(a) RESIDENCE NO. 1934 E. Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Paul McSouthcomb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Ethel Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Paul McSouthcomb
(Address) 1934 E. Chase St

JUN 3 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1924, to June 2, 1924,

that I last saw him alive on June 2, 1924,

and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Bronch-Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Following Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Carman, M. D.

62, 1924 (Address) 1201 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 3 1924

20 UNDERTAKER: Furkler & Furkler — ADDRESS: 1239 Fagan

Spec.—6-9-15—H. P. Co.—1000 Bks.

D 87528

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 S Schroeder ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Frederick Werner

(a) RESIDENCE. No. 108 S. Schroeder ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Goller Werner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothing Designer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant (Address) Arthur L. Grace 108 S Schroeder St

15 Filed ....., 19.. ROBERT R. KRAUTH, Registrar

JUN 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1924

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1924, to June 1st, 1924, that I last saw him alive on June 1st, 1924, and that death occurred, on the date stated above, at 12:00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Right Inguinal Region (duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm. L. Triplett, M. D.

, 19 (Address) 1324 N. Loudon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 3, 1924

20 UNDERTAKER	ADDRESS
John O. Mitchell	220 N Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D 87529

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 233 N. Wallace ST. 6 WARD)

2-FULL NAME Chas. Thompson

(a) RESIDENCE NO. 233 N Wallace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced
~~WIFE~~ HUSBAND of Martha Thompson

6 DATE OF BIRTH (month, day, and year) ? ? 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Coal Miner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rocky Point N.C.

PARENTS

10 NAME OF FATHER A.D. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Hannah Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Robert Thompson Brother
(Address) 233 N. Wallace St

JUN 3 - 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1924, to June 3, 1924.

that I last saw him alive on June 2, 1924,

and that death occurred, on the date stated above, at 12 30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Lambertson Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Young, M. D.

6/3, 1924 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rocky Point. N.C	4 June 1924
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans

Spec. 1-10-21 M&T 1500 Bks.

Heinsler

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87530

100-001

D 87530

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 N Broadway St., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hebron Heinsler

(a) RESIDENCE NO. 1611 N Broadway ST., WARD 8

(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary E Heinsler

6 DATE OF BIRTH (month, day, and year) May 7 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84		24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Officer 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER John F Heinsler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mary E Heinsler Son (Address) 1611 N Broadway

15 Filed JUN 3 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17 I HEREBY CERTIFY, That I attended deceased from May 29th, 1924, to May 31, 1924, that I last saw h~~im~~ alive on May 31, 1924, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Congestion of Lungs

and acute Bronchitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Thomas Timmins, M. D.

, 19 (Address) 1025 W Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/4/24 19

20 UNDERTAKER George J Ruth

ADDRESS 1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87531

CERTIFICATE OF DEATH.

90 ✓ D 87531

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Johnson

(a) RESIDENCE. NO. 911 Middle Court ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 060

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER William R. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Snow Hill, Md.

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 3 - 1924 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 2 1924

17

I HEREBY CERTIFY, That I attended deceased from 4 - 10 . 1924. to 6 - 2 . 1924

that I last saw him alive on 6 - 1 . 1924

and that death occurred, on the date stated above, at 7¹⁵ a. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
myocardial insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude C. Horne, M. D.

6-2 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. L.	June 4 1924

20 UNDERTAKER Sam'l W. Case & Son ADDRESS 1400 Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87532 CERTIFICATE OF DEATH.

16 D 87532

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Johnston ST., 17 WARD)

2-FULL NAME Baby Boy Brinkley

(a) RESIDENCE NO. 502 N. Johnston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. 34 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Willis Brinkley

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) U.S.

14 Informant [illegible]
(Address)

15 JUN 3 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1924, to June 1st, 1924, that I last saw him alive on June 1st, 1924, and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prolonged Labor

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Isaac A. Knapp, M. D.

6-2, 1924 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUN 3 - 1924
20 UNDERTAKER	ADDRESS
[illegible] Smith.	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87533

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 545 W. Preston ST., 17 WARD)

2-FULL NAME Baby Boy Fosque

(a) RESIDENCE No. 545 W. Preston ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

1601-001

D 87533

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 2nd 24

7 AGE — Years — Months — Days — If LESS than 1 day 6 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Lee Fosque

11 BIRTHPLACE OF FATHER (city or town) (State or country): Accomac Va.

12 MAIDEN NAME OF MOTHER: Mary Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Berkley Va.

14 Informant (Address): Father

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
JUN 3 - 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2 . 1924. to June 2nd 1924.
that I last saw him alive on June 2nd . 1924
and that death occurred, on the date stated above, at 1.15 P. m.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ✓ Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Louis H. Douglass, M. D.

(Address) Univ. Hospital 6-2-1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUN 3 - 1924

20 UNDERTAKER: Commissioner Health

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

176

Spec. 1-10[illegible] Mks.

D 87534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87534

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 N. Stricker ST., 15 WARD)

REGISTERED NO. 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lindsey

(a) RESIDENCE NO. 1321 N. Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.
			1	11 hrs. 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 1321 N. Stricker St. Baltimore, Md.

PARENTS

10 NAME OF FATHER Perry Lindsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Margaret Lindsey
(Address) 1321 N. Stricker Baltimore, Md.

15 JUN 3 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-1- , 1924, to 6-1- , 1924, that I last saw him alive on 6-1 , 1924 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Susanne R Parsons, M. D.

6-1- 1924 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL June 3, 1924

20 UNDERTAKER Mrs Jas H. Dennis

ADDRESS 1303 Pressman St.

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87535

CERTIFICATE OF DEATH.

40 D 87535

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Faith Lane ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Downey

(a) RESIDENCE No. 1619 Faith Lane ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colrd	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Mary~~ Mattie Downey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
54 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream making

(c) Name of employer Horn & Co Ice Cream Mnfgr

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mattie Downey (Address) 1619 Faith Lane

15 Filed JUN 3 - 1924 ROBERT R. KRAUTER Registrar

Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to May 30, 1924, that I last saw h alive on May 30, 1924, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Coma gastritis & Uremia

Dept in State of Coma

Anaemia Complication of Burns

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Stricture of urethra

(duration) 30 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas J Dimmis, M. D.

, 19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 3 1924

20 UNDERTAKER Wm H. E. Elliott

ADDRESS 1725 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 87536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87536

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Homewood Hospital

CITY OF BALTIMORE: (No. 2724 N Charles Street ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malvina Leak

(a) RESIDENCE NO. 835 N Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Leak

6 DATE OF BIRTH (month, day, and year) June 16 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Barney C Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Frances McCade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John Leak

(Address) 835 N Franklin St

15 Filed JUN 5 1924 Robert P. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1924, to June 2, 1924.

that I last saw her alive on June 2, 1924,

and that death occurred, on the date stated above, at 7.35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

Unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/14/24

Was there an autopsy? Yes

What test confirmed diagnosis?

Signed [illegible] M. D.

6/7/1924 (Address) 2724 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL June 6 1924

20 UNDERTAKER Samuel T Kennedy

ADDRESS 678 N Eutaw

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87537

CERTIFICATE OF DEATH.

162 D 87537

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Eastland Ave ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Caroline Herold

(a) RESIDENCE NO. 2308 Eastland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1924

7 AGE — Years — Months — Days: 3 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Frank J. Herold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Sophie Havlik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho-Slovakia

14 Informant Frank J. Herold (Address) 2308 Eastland Ave.

15 Robert P. Harrison, Registrar

JUN 3 - 1924

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 3, 1924, that I last saw her alive on June 3, 1924 and that death occurred, on the date stated above, at 9.55 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vincent V. Dooley M. D.

, 19 (Address) 845 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 4 1924

20 UNDERTAKER: Frank Coordsey — ADDRESS: 1906 Eastland

Spec.—1-10-21—M&T—1500 Blks.

D 87538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87538

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 W Baltimore St., 21st WARD)

2-FULL NAME William J Jenkins

(a) RESIDENCE NO. 2115 W Baltimore St WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E Jenkins

6 DATE OF BIRTH (month, day, and year) June 20 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Forman City Eng

(b) General nature of industry, business, or establishment in which employed (or employer) Dept

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hampton Va

PARENTS

10 NAME OF FATHER Lodrick Jenkins

11 BIRTHPLACE OF FATHER (city or town) Rochester (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Lawson

13 BIRTHPLACE OF MOTHER (city or town) Hope Hill (State or country) Maryland

14 Informant Mrs Sarah E Jenkins

(Address) 2115 W Baltimore St

15 JUN 3 - 1924 Robert P. Harrison, ...19.... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to June 1, 1924, that I last saw him alive on June 1, 19..., and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Bronchitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. E.

(Signed) Jolue S. Bishop, M. D.

, 19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	JUNE 4 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87539

CERTIFICATE OF DEATH.

31 D 87539

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Talbot

(a) Residence No. 2258 Morris st. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1902

7-AGE. 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joe Butler

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Mary Fennett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Hospital Records

(Address) M. T. H.

15- Filed JUN 3 1924 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 15 1924 to June 1 1924

that I last saw her alive on June 1 1924

and that death occurred, on the date stated above, at 6.15 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

6-2-24 19 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Peters Cemetery	June 4 1924
20-UNDERTAKER,	ADDRESS
Mrs Jas H Dennis per T.E. Kelson.	1333 Pennsylvania Ave

Burial Permit Clerk.

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

17342 Ped D 87540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X-155 D 87540

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 1-

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Vaughan

(a) RESIDENCE NO. 18 Todd St Washington D.C. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 10-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child FW

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Walter Vaughan

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Alabama

12 MAIDEN NAME OF MOTHER Clara Jenkins

13 BIRTHPLACE OF MOTHER (city or town) ... (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL.

15 JUN 3 - 1924 Robert P. Harrison, M.D. Registrar

Burial Forest Park.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to June 3, 1924.

that I last saw h[illegible] alive on June 3, 1924.

and that death occurred, on the date stated above, at 9 30 a.m.

The CAUSE OF DEATH* was as follows:

Septicemia

Acute Pyogenic Staphylococcus

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Mastoiditis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home 5/31/24

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R Bagg M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C.

DATE OF BURIAL 6/3 1924

20 UNDERTAKER Chas. F. Bruce & Son

ADDRESS 1118 Mt Royal Ave

WARNING—RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87541

CERTIFICATE OF DEATH.

122 D 87541

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 3 Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Zeleska

(a) RESIDENCE. No. 816 S. Bond St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe-maker

(b) General nature of industry, business, or establishment in which employed (or employer) 188

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown ?

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 3 - 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 2 1924

17 I HEREBY CERTIFY, That I attended deceased from 5 - 29, 1924 to 6 - 2, 1924

that I last saw him alive on 6 - 1, 1924

and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Job.

(Signed) Claude S. Dorsey, M. D

6-2 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	June 4 1924

20 UNDERTAKER

ADDRESS

Jacob Tial Funeral Dir. 426 S. Bond St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FOR BINDING

ALL RIGHTS RESERVED

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87542

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1816 Clifton Ave St., 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Marguerita Palmisano

(a) Residence No. 1816 Clifton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fe. male

4-COLOR OR RACE, white

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 6th 1923

7-AGE. yrs. 10 mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Brooklyn (State or Country) New York

PARENTS.

10-NAME OF FATHER, August Palmisano

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Constance DiGiorgio

13-BIRTHPLACE OF MOTHER (city or town) Washington (State or Country) D. C.

14- (Informant) August Palmisano

(Address) 1816 Clifton Ave. Balto. Md.

15- Filed 6-3 1924 Robert F. Harrison, Registrar.

Burial Permit Sent

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2nd 1924

17- I HEREBY CERTIFY, That I attended deceased from May 26th 1924 to June 2nd 1924

that I last saw her alive on June 2nd 1924

and that death occurred, on the date stated above, at 8:00 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Roentgen

(Signed) Edward C. Reichert M. D.

6/3, 1924 (Address) 2734 Pa Ave. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery DATE OF BURIAL, June 4, 1924

20-UNDERTAKER. Martin Stakes Son ADDRESS 2011 W North Ave

JUN 3 - 1924

Filed. 1925 120c

X 100-01

✓

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—(No. 1), 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 3 M 3 D 87543

71-00 D 87543

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ~~605 Lemith St.~~ 14 ST., WARD)

2-FULL NAME Dorothy Dixon

(a) RESIDENCE NO. 605 Lemith St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): Child.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 23, 1915

7 AGE: Years 8 | Months 11 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Georgie Bullett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 JUN 3 - 1924 Robert P. Harrison, Registrar

Burial Permit Out

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1924

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to June 1, 1924

that I last saw h[illegible] alive on June 1, 1924,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Primary pneumococcus meningitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of May 30

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) H. N. Wasch, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt auburn cem | DATE OF BURIAL: 6/4 1924

20 UNDERTAKER: Leon Hall | ADDRESS 753 Dolphin

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87544

CERTIFICATE OF DEATH.

D 87544

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2538 Lauretta (St.:) 70 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Loesch

(a) RESIDENCE: No. 2538 Lauretta St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Loesch

6 DATE OF BIRTH (month, day, and year) May - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Basket Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Mod. worked for Bland

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lichtenfeld Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo Loesch (Address) 2538 Lauretta ave

15 Filed JUN 3 - 1924 Robert P. Harris Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to June 2, 1924.

That I last saw him alive on June 2, 1924.

and that death occurred, on the date stated above, at 8:20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 5 Hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis - Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jas L. Hooper, M. D.

6-2, 1924 (Address) 346 E. 28th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	6-5 1924
20 UNDERTAKER: Daniel Earhart	ADDRESS 946 Pa ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D 87545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87545

CERTIFICATE OF DEATH.

113

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 722 Bruns St. ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Lucky

(Residence in Baltimore: No. 722 Bruns St. St.; 1 yrs., 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	Colored	single

6-DATE OF BIRTH. Sept. 20, 1922
(Month) (Day) (Year)

7-AGE, 1 yrs. 8 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Ed. Lucky

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Fannie Lucky

13-BIRTHPLACE OF MOTHER (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed. Lucky

(Address) 722 Bruns St.

15- Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) .....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) .....yrs.....mos.....ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

June 2, 1924 (Address) 2802 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem	6-4, 1924
20-UNDERTAKER. David Easton	ADDRESS 916 Gay ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

N3 -1924

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87546

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87546

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

2-FULL NAME Miss Beddie Cornwell.

(a) RESIDENCE NO. Garrison, Md ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Never yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 18/1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employed at

(b) General nature of industry, business, or establishment in which employed (or employer) Colton Mills 946

(c) Name of employer Woodbury.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oddie Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mollie McCauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Frank Carroll
(Address) Garrison Md.

15 JUN 3 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1924. to June 2, 1924.

that I last saw he alive on June 2, 1924

and that death occurred, on the date stated above, at 4.55 P. m.

The CAUSE OF DEATH* was as follows:

Miscarriage.

Puerperal Sepsis. (Cause)

(duration) yrs. mos 11 da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Patient had curet.

Was there an autopsy? History & Clinical findings.

What test confirmed diagnosis?

(Signed) B. M. Rhodes, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Church. Wurton Md	June 4th 1924
20 UNDERTAKER	ADDRESS
Wilbur W. Shriver	1018 Edmondson Ave.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87547

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87547

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 30 S. Ellwood Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Meinschein

(a) Residence No. 30 S. Ellwood Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Meinschein

6-DATE OF BIRTH (month, day and year) March 14, 1835

7-AGE. 89 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER. George Manns

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Margaretha Ditzel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Frederick Meinschein

(Address) 30 S. Ellwood Ave

15- JUN 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 2, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 8 1923. 1923 to May 20 1924

that I last saw h[er] alive on May 20 1924

and that death occurred, on the date stated above, at 6 40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright Disease

(Duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senility

5 (Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home, where she died

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Urine test & Microscopic

(Signed) George C. E. Taylor M. D.

19 (Address) 18 N. Howard St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19....
St Pauls Cem.	6/4/24
20-UNDERTAKER,	ADDRESS
H Sander & Sons	1716 Gilbert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87548

CERTIFICATE OF DEATH.

113

D 87548

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 822 N. Mount St.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Jones

(Residence in Baltimore: No. 822 N. Mount St.; yrs., 9 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	colored	single

6-DATE OF BIRTH. August 7, 1923
(Month) (Day) (Year)

7-AGE. ....yrs. 9 mos. 26 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Addison Jones

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Hattie Davis

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Jones

(Address) 822 N. Mount St.

15-

JUN 4 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) No History

(Duration).....yrs.....mos.....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 3, 1924 (Address) 702 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	June 4, 1924
20-UNDERTAKER	**ADDRESS**
H. G. Brown & Son	108 N. Monty Ave

Cor.—1-12-23—M&T—100 Bks.

D 87549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 87549

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 E. Church St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam W. Glasser.

(a) RESIDENCE NO 1522 Clarkson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~XXXXXX~~ (or ~~WIFE~~ of ~~XXXXXX~~) Maggie Glasser.

6 DATE OF BIRTH (month, day, and year) August 9, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) City Hall.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

10 NAME OF FATHER Peter Glasser.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Elizabeth. -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

Informant Maggie Glasser. (wife)
(Address) 1522 Clarkson St.

Filed JUN 4 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st. 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

June, 3, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet. Cem. DATE OF BURIAL 6/4 1924

20 UNDERTAKER J. Fenn McCully ADDRESS 130 E. Fort

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87550

CERTIFICATE OF DEATH.

1924 D 87550

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 24 WARD)

2-FULL NAME Hiram D. McNaney.

(a) RESIDENCE NO 508 E. Barney St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Julia E. McNaney.

6 DATE OF BIRTH (month, day, and year) January 20, 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 10 04
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry McNaney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Eleanore Yewell,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Julia E. McNaney. (wife)
(Address) 508 E. Barney St.

15 Filed JUN 4 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st. 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest. (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Intra Cranial Hemorrhage due to
Fracture of the Skull,
Assaulted & knocked down
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Homicide
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

June, 3, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Webster & Harvey Sts, June 1st. 1924.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 6/4 1924

20 UNDERTAKER E. Frew McCully

ADDRESS 130 E. Fort

CAUSE OF DEATH in plain language. Exact... so that it may be properly classified.
TION is very important. See instructions on back of certificate.

12

Cor.—1-12-23—M&T—100 Bks.

(John Mlyczarczyk)

D 87551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87551

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 717 S Bond ST., X WARD)

2-FULL NAME John Mlyczaczczyski (or Mlyczarczyk)

(a) RESIDENCE NO 717 S Bond ST., WARD 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant John M Weber
(Address) 1803 Bank St

15 Filed JUN 4 - 1924, 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Indigestion
Dil Stomach

DURATION (duration) yrs. mos 2 hrs

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

(Signed) Jos Clinton Blades M. D.
(Coroner.)

6/3/24, 192 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 4 1924
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state ... statement of OCCUPATION ... terms.

D 87552

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114

D 87552

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1641 N. Payson St. St.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Liebeman

(Residence in Baltimore: No. 1641 N. Payson St. St.: 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
female	white	married

6-DATE OF BIRTH. about ....., 1862
(Month) (Day) (Year)

7-AGE. 62 yrs. ..... mos. ..... ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 37

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER, Michael Friedman

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Lennie ?

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. Baltimore St.

15-

Filed ..... 19.. ROBERT P. KRAUTER Registrar.

JUN 4 - 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

acute gastro-enteritis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 3, 1924 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hebrew Rosedale	6/4, 1924
20-UNDERTAKER Jack Lewis	ADDRESS 1439 E Balt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87553 — REGISTERED NO. D 87553

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N. Bruce ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Holley

(a) RESIDENCE. NO. 225 N Bruce ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Holley

6 DATE OF BIRTH (month, day, and year) March 10 74

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) General housework

(c) Name of employer Mrs Luther Gwaltney

9 BIRTHPLACE (city or town) (State or country) Gloucester Co Va.

PARENTS

10 NAME OF FATHER Samuel Jones

11 BIRTHPLACE OF FATHER (city or town) Gloucester (State or country) Co. Va.

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) Gloucester (State or country) Co Va

14 Informant Sosha Jones (Address) 225 N. Bruce St

15 JUN 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1924, to June 2, 1924, that I last saw h.. alive on June 2, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Subchronic Nephritis.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright, M. D.

June 3. 1924 (Address) 1209 N. Bruce St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6/6 19 24

20 UNDERTAKER Daniel Easton ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 87554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 87554

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Mc Culloh ST., 14 WARD)

2-FULL NAME Mabel Taylor

(a) RESIDENCE NO. 1903 Mc Culloh ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm H. Taylor

6 DATE OF BIRTH (month, day, and year) Jan 11, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	31	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliza Stepney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wm H. Taylor
(Address) 1903 Mc Culloh St

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

JUN 4 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26th 24 to June 1st 24

that I last saw h~~is~~er alive on May 31st 1924,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was ~~as follows~~:

Pul. Tuberculosis,

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Whooping Cough,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Ellis, M. D.

6/3, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 6/5 - 1924

20 UNDERTAKER Daniel Easton — ADDRESS 96 Dean

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87555

CERTIFICATE OF DEATH.

31 D 87555

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S.Montford Ave ST., 1 WARD)

2-FULL NAME VICTORA E.PILACHOWSKI,

(a) RESIDENCE NO. 703 S.Montford Ave ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 5 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female,	White,	Single,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 19/97.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
26	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Factory, 017

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER John Pilachowski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Frances Zaminski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland, ~~PAUX~~

14 Informant Frances Pilachowski,
(Address) 703 S.Montford Ave

15 Filed JUN 4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3 1924

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1924, to June 3, 1924, that I last saw h[illegible] alive on June 1, 1924, and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Samuel [illegible], M. D.

, 19 24 (Address) 332 S Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 7-1924
20 UNDERTAKER M. F. Sadowski.,	ADDRESS 905 S. Ann

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87556

CERTIFICATE OF DEATH.

74-001

D 87556

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3113 Oakfield Ave. St., Forest Park Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Albert Bertuch.

(a) Residence No..... 3113 Oakfield Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Leegth of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (write word.)
Male	White	Married.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Bertuch

6-DATE OF BIRTH (month, day and year) Aug. 20, 1873.

7-AGE. 51 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or....mIn.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kiud of work..... Retired Mnfgr.

(b) General nature of industry, business, or establishment in which employed (or employer) Ladies Wear.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany.

PARENTS.

10-NAME OF FATHER, David Bertuch

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Hannah Strauss

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany.

14- (Informant) Mrs. Lottie Bertuch

(Address) 3113 Oakfield Ave.

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

JUN 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/3/24.

17- I HEREBY CERTIFY, That I attended deceased from May 31st 19 24 to June 3d 19 24.

that I last saw him alive on June 3d 19 24

and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy, Right Hemiplegia

Paralysis of years

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis, Bright's

(Duration) 5 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Jos. H. Richter M. D.

(Address) 15 76 Madison Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Balto. Hebrew Cem.	6/6/24. 19....
20-UNDERTAKER. David Sondheim	ADDRESS 1115-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D 87557

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. D 87557 Homewood Hosp. St., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Clark #2

(a) RESIDENCE No. 1000 Falls Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 1 Falls Rd, Md

PARENTS

10 NAME OF FATHER Clarence E. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savage Md

12 MAIDEN NAME OF MOTHER Ruby Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aberdeen Md

14 Informant C. E. Clark
(Address) 1000 Falls Rd

15 JUN 4 - 1924 ROBERT R. KRAUTER, Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1924, to 6/2, 1924

that I last saw him alive on 6/2, 1924,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

6 Mo. Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6/3, 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUN 4 - 1924

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

178

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-00 D 87558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 87558

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Homewood Hosp ST., 13 WARD)

2-FULL NAME Baby Clark #1.

(a) RESIDENCE NO. 1000 Falls Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs or ..... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (illegible)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence E. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savage Md.

12 MAIDEN NAME OF MOTHER Ruby Lauder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aberdeen Md.

14 Informant C. E. Clark
(Address) 1000 Falls Rd

15 Filed JUN4 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1924, to 6/2, 1924.
that I last saw him alive on 6/2, 1924,
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
6 Mo. Premature birth

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.
6/3, 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS JUN4 - 192

JOHNS HOPKINS HOSPITAL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DO NOT FOLD OR USE RUBBER BAND IN FILING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87559

101-001

CERTIFICATE OF DEATH.

D 87559

REGISTERED NO.

1-PLACE OF DEATH 1230 E. Monument St

CITY OF BALTIMORE: (No. ~~Charles Co~~ ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Campbell

(a) RESIDENCE NO. 1230 E. Monument St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Campbell

6 DATE OF BIRTH (month, day, and year): Aug 10 1887

7 AGE: Years 36 Months 10 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Helen Campbell

(Address): 1230 E. Monument St.

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar

JUN 4 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 19 24

17

I HEREBY CERTIFY, That I attended deceased from May 29, 19 24, to June 2, 19 24,

that I last saw h[illegible] live on June 1, 19 24,

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert H. Lee, M. D.

6/2/24 (Address) 1730 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL: June 6 19 24

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1726 Eastland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87560

CERTIFICATE OF DEATH.

90 D 87560

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1640 N North Ave ST., 15 WARD)

2-FULL NAME Charles Copenspire

(a) RESIDENCE NO. 1640 N North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Copenspire

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Charles Copenspire

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs John F Woodward

(Address) 1640 N North Ave

15 Filed JUN 4 - 1924 19 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1924 to June 3, 1924,

that I last saw h— alive on June 2, 1924,

and that death occurred, on the date stated above, at 6.55 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James R. Spurling, M. D.

6/4, 1924 (Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae	June 6 1924
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87561

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

D 87561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 524 Lyndhurst St. St., 20th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Rosa Deichmiller

(a) Residence No. 524 Lyndhurst St. St., Ward 20th
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? 32 yrs. 6 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced wife of HUSBAND of (or) WIFE of Ferdinand J. Deichmiller

6-DATE OF BIRTH (month, day and year) Jan 19th June, 1892

7-AGE	If LESS than 1 day,
32 yrs. 6 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.

10-NAME OF FATHER: Theodore H. Katenkamp

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Maryland

12-MAIDEN NAME OF MOTHER: Emelia Line

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Ferdinand J. Deichmiller

(Address): 524 Lyndhurst St

15-

FILED JUN 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 2nd 1924

17- I HEREBY CERTIFY, That I attended deceased from July 20th, 1923, to June 2, 1924, that I last saw h.e alive on June 2 —, 1924, and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Laryngeal Tuberculosis

(Duration) 2 yrs. ? mos. ? ds.

CONTRIBUTORY
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 2/12/23

Was there an autopsy? No

What test confirmed diagnosis? Tuberculosis

(Signed) Wm. A. Fisher M. D.

6/3/, 1924 (Address) 827 N. Chester St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
St Paul's Cemetery	6/5/1924

20-UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87562

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87562

CERTIFICATE OF DEATH.

101-09

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1102 N. Monroe ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank W Schofield

(a) RESIDENCE NO. 1907 Mulberry ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced. (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Cary Schofield

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Hardware business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Deceased - Alfred Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Irma Aschenbrenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Mrs. Cary Schofield 1907 Mulberry St

JUN 4 - 1924

ROBERT R. KRAUSER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1924

I HEREBY CERTIFY, That I attended deceased from May 27, 1924 to June 3, 1924

that I last saw h alive on June 3, 1924

and that death occurred, on the date stated above, at 9.20A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

4 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. A. Dyson, M. D.

, 19 (Address) Colonial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL June 5 1924

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 37563

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 37563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 Homestead Street, ST. No WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie L.Beach

(a) RESIDENCE. NO. 22 Homestead Street ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life s. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J,Beach.

6 DATE OF BIRTH (month, day, and year) May 11,1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Burgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Heneretta Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Walter J. Beach 22 Homestead Ave.

15 JUN 4 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1924, to June 3rd, 1924, that I last saw her alive on June 3rd, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 5 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Robert L Kirk, M. D.

6/3. 1924 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	6/6/ 1924
20 UNDERTAKER Albert L Hilty Jr	ADDRESS 1606 N Chester St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87564

1-PLACE OF DEATH 1430 North Broadway 8 7 Registered No.....

City of BALTIMORE: (No. 1430 N. Broadway St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura V. Starr

(a) Residence No. 1430 N. Broadway St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.)
Female	White	Married

5a-If married, ~~widowed~~, or ~~divorced~~, ~~HUSBAND~~ of (or) WIFE of Edner L. Starr

6-DATE OF BIRTH (month, day and year) Mar 31 1857

7-AGE.	If LESS than 1 day.
67 yrs. 2 mos. 1 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, J. H. Sturgeon

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Edner L. Starr (husband)

(Address) 1430 N. Broadway

15- JUN 4 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2 1924

17- I HEREBY CERTIFY, That I attended deceased from May 29 1924 to June 2 1924

that I last saw her alive on June 2 1924

and that death occurred, on the date stated above, at 5:55 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(Duration) 3 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) C. C. McDonald M. D.

June 2, 1924 (Address) 1540 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cemetery	June 6 1924
20-UNDERTAKER Robt J. Turner Sons	ADDRESS 1942 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87565

CERTIFICATE OF DEATH.

161-09 ✓ 87565

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 E 20 St. W 2 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Jefferson

(a) RESIDENCE NO. 24 E 20th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

30 minutes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2nd 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Ceaser Jefferson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Hattie Matthews

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant (Address) 24 East Jefferson 20th St

15 Filed JUN 4 - 1924, 192 Hebert F. Harris
Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

1924 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem-	2nd June 192
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

MARGIN RESERVED FOR BINDING

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-2;—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87566

CERTIFICATE OF DEATH.

D 87566

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hughes

(a) Residence No. 713 Granby St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced.~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) May 30. 1911

7-AGE 13 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER John J Hughes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ella J Dempsey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

11- (Informant) John J Hughes

(Address) 713 J Granby St

15- Filed JUN 4 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2 - 24

17- I HEREBY CERTIFY, That I attended deceased from May 31 19 24 to June 2 19 24

that I last saw him alive on June 2 19 24

and that death occurred, on the date stated above, at 4 PM.

The CAUSE OF DEATH* was as follows:

Ileal. Peritonitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ruptured Appendix

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/31/24

Was there an autopsy? No

What test confirmed diagnosis? Phys Hdgs & Lab

(Signed) H O Harper M. D

, 19 (Address) Hdgs Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL, 6-5- 1924

20-UNDERTAKER, H C Braumgardner

ADDRESS 571 N. Schroeder St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

121914 D 87567 — 100-001 ✓ D 87567

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 4 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Junior Wanning

(a) RESIDENCE NO. 655 Vine St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) — 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
—	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Junior Wanning
11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica
12 MAIDEN NAME OF MOTHER Annie
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 JUN 4 - 1924 Robert F. Harrison, Registrar
Robert F. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1924 to May 23, 1924.
that I last saw him alive on May 23, 1924.
and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) yrs. mos 8 ds.
CONTRIBUTORY (Secondary) Emphysema
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Chas. R Bagg, M. D.
, 19 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS JUN 4 - 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Springer)

D 87568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87568

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME Mary E. B. Springer

(a) RESIDENCE NO. 2528 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Rev. Thomas L. Springer

6 DATE OF BIRTH (month, day, and year) May 19 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House-wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester Pa.

PARENTS

10 NAME OF FATHER Frederick Bowker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Rachael Ann Gould

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Rev. Thomas L. Springer

(Address) 2528 N. Calvert St

15 JUN 4 - 1924 Robert P. Harrison, Registrar

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3/24

17 I HEREBY CERTIFY, That I attended deceased from April 30/24, 19..., to June 3/24, 19..., that I last saw her alive on June 3/24, 19..., and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Thos. B. Horton M.D.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Contused Tumor Covered

(duration) 5 Wks yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos. B. Horton M. D.

June 5 19 (Address) 1203 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL June 5 1924

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

OK for Southwestern District

Baltimore City Health Department Southwestern District

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 87569

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3810 Roland Ave 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy H. Lindsay

(a) Residence No. 3810 Roland Ave St., 13 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 3, 1882

7-AGE, 42 yrs. mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Forewoman 14 & 20 Room

(b) General nature of industry, business, or establishment in which employed (or employer)... Med. Chemists

(c) Name of employer... Sharpe & Dohme

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER, Richard A. Lindsay

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Caroline Hughlett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Caroline Lindsay

(Address) 3810 Roland Ave

15- Robert P. Harrison,

Filed....., 192.... Registrar.

UN4 - 1924 Buried Dorsett Park.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 2-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct, 1923, to June 2, 1924

that I last saw h.er alive on June 2, 1924

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Duration) 9 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab-Urinary-Casts

(Signed) Frank W. Hall, M. D.

6/2, 1924 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	June 5 1924
20-UNDERTAKER	ADDRESS
Horace H. Burgess	3[illegible] Falls Rd.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Blks.

(Dammann)

D 87570

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87570

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.

City of BALTIMORE, No. 1132 Carroll 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav R Dammann

(a) Residence No. 1132 Carroll St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 1 mos. 20 ds. — How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male | 4-COLOR OR RACE: White | 5-Single, Married, Widowed or Divorced (Write which): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mollie E

6-DATE OF BIRTH (month, day and year): Mar 13-1891

7-AGE: 33 yrs. 1 mos. 20 ds. — If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (City or Town) (State or Country): Baltimore Md

PARENTS:
10-NAME OF FATHER: Louis R.
11-BIRTHPLACE OF FATHER (City or Town) (State or Country): Germany
12-MAIDEN NAME OF MOTHER: Markum
13-BIRTHPLACE OF MOTHER (City or Town) (State or Country): Germany

14-Informant: Mrs Dammann
(Address) 1132 Carroll St

15-Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 24

17- I HEREBY CERTIFY, That I attended deceased from May 26 19 24 to June 3 19 24

that I last saw him alive on June 3 19 24

and that death occurred, on the date stated above, at 10-20 a.m.

The CAUSE OF DEATH* was as follows:

Pul. Hemorrhage

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pul TB

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J Schwemmer M. D.

(Address) 11 Mt Vernon Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Pk Cemetery	June 6 1924
20-UNDERTAKER.	ADDRESS
Geo Leimbach & Son	647 W Pratt St

WHITE—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

N4 -1924

Spec. 1-10-21 M&T 1500 Blks.

D 87571

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87571

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. Estelle Dance ST., WARD)

2-FULL NAME Fannie Dance

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2405 Sarrison Boulevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clifton Dance

6 DATE OF BIRTH (month, day, and year) Aug 3 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edwin C. Snyder

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Sophia Dawson

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Edwin C. Snyder (Address) 710 Lemmon

15 Robert P. Harrison, 19 Registrar

JUN 4 - 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to June 2, 1924.

that I last saw her alive on June 2, 1924

and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

1 Chronic Myocarditis

2 Ovarian Cyst 1-10 years

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) James Hubert Abercrombie, M. D.

19 (Address) Maryland Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 1924

20 UNDERTAKER H. C. Friedenwald — ADDRESS Norths

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87572

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-60 D 87572

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos. E. Johnson

(a) RESIDENCE NO. 1924 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Mar 16/24

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
		2	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas A. Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma C. Hoffmeyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Thomas A. Johnson
(Address) 1924 E. Chase St

15 Filed , 192 Robert P. Harrison, Registrar

JUN 4 - 1924 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Kollen, M. D. (Coroner.)

June 3, 1924 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	6/5/1924

20 UNDERTAKER C. J. Canning & Son ADDRESS 1938 E. Lafayette Ave

THIS IS A PERMANENT RECORD. Every item must be filled in with PEN AND BLACK INK—THIS IS IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 87573

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 E. Fort Ave. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George L. Busick.

(a) RESIDENCE No 409 E. Fort Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 10, 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street sweeper.

(b) General nature of industry, business, or establishment in which employed (or employer) City of Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George L. Busick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary A. Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. S. B. James. (aunt)

(Address) 409 E. Fort Ave.

15 Filed ....., 192 Robert F. Harrison, Registrar

JUN 4 - 1924

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Brachial Cleft Cyst (right) extending into the Larynx and Oesophagus.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

June 3, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N.W. Carmel Cemetery	6/5/1924
20 UNDERTAKER	ADDRESS
E. J. Fanning Sen - 1460	Battery Ave

INSTRUCTIONS

This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-901 D 87574

1-PLACE OF DEATH South Balto Gen Hospital

CITY OF BALTIMORE: (No.) 1213 Lt St ST., (If HARD) Nearest

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur William Myers Jr.

(a) RESIDENCE No. 743 Cenmington ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24-1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Arthur Wm. Myers Sr.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Columbus Ohio

12 MAIDEN NAME OF MOTHER Viola M. Harman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Arthur M. Myers
(Address) 743 Pennington Ave

15 Filed JUN 4 1924, 19... Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/4, 19 24, to 6/4/24, 19 ,
that I last saw h— alive on 6/4/24, 19 ,
and that death occurred, on the date stated above, at 4:20 P m.
The CAUSE OF DEATH* was as follows: Icterus Neonatorum (Hemolytic)

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

, 19 (Address) 1629 Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	6/5 1924
20 UNDERTAKER	ADDRESS
J Margaret E. Flynn	1432 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GNED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87575

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D 87575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1602 N. Regester St., 8 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora M. Roubal

(a) Residence No. 1602 N. Regester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., If of foreign birth? 36 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Chas. A. Roubal

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 53 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037
(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Austria

PARENTS

10-NAME OF FATHER Albert. Vopalecky

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Austria

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14- (Informant) Mr. Charles A. Roubal
(Address) 1602 N. Regester St.

JUN 5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4 1924

17- I HEREBY CERTIFY, That I attended deceased from May 2 1924 to June 4 1924

that I last saw h... alive on June 4 1924

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Chas. E. Telgmann M. D.

June 4 1924 (Address) 4 W. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	June 7, 1924
20-UNDERTAKER.	ADDRESS
Henry Koch Son	1301 E Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 87576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 001 D 87576

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 N. Carey st ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecile I. Rainey

(a) RESIDENCE. No. 600 N. Carey ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) ~~WIFE OF~~

6 DATE OF BIRTH (month, day, and year) Oct 1-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Rainey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret A. Rainey (Address) 600 N. Carey St

15 JUN 5 - 1924 ROBERT B. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1924, to June 3, 1924, that I last saw her alive on June 3, 1924, and that death occurred, on the date stated above, at 1.35 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. K. Dreibel M. D.

6/4. 1924 (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 6 1924
20 UNDERTAKER	ADDRESS
Chas. E. Franck & Son	Madison &

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87577

CERTIFICATE OF DEATH.

D 87577

1-PLACE OF DEATH CITY OF BALTIMORE: (No. Mercy Hospital ST., 15 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. E. Snyder.

(a) RESIDENCE No 1951 W. North ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie B. Snyder

6 DATE OF BIRTH (month, day, and year) April 10 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Cashier
(c) Name of employer United Fruit Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Isaac H. Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Laura Dyford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Minnie B. Snyder
(Address) 951 W. North Ave

15 JUN 5 - 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning 1 yr

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

(Signed) Geo. E. Wade, M. D.

6/3/24 (Coroner) (Address) 1426 K Fonay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 6 1924
20 UNDERTAKER	ADDRESS
Chas. E. Francis	802 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 87578

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 65-5 Penn Ave ST., 4 WARD)

2-FULL NAME Elsie Staples

(a) RESIDENCE NO 65-5 Penn Ave St- ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown. yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Leonard Whaley
(Address) 623 Spring St

15 Filed JUN 5 - 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2— 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest au- ..... (topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pulmonary Tuberculosis

Don't Know (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) T R Graybeal, M. D. (Coroner.)

6/5, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	6/5/24
20 UNDERTAKER R C Gross	ADDRESS 1405 N Eden

(Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87579

CERTIFICATE OF DEATH.

160 D 87579

1-PLACE OF DEATH CITY OF BALTIMORE, (No. 5030 Renaissance Rd St.; 28 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Clyde Valliant

(Residence in Baltimore: No. 5030 Renaissance Rd. St.; .....yrs., ...mos. .....ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 18 (Day), 1923 (Year)

7-AGE, 7 yrs. 7 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Stephen Valliant

11-BIRTHPLACE OF FATHER (State or Country), Md -

12-MAIDEN NAME OF MOTHER Grace Prescott

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Valliant

(Address) 5030 Renaissance Rd

15- JUN 5 - 1924 ROBERT A. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1924, to June 4 1924, that I saw h[illegible] alive on June 3 1924, and that death occurred, on the date stated above, at 12.20 a m.

The CAUSE OF DEATH* was as follows:

I.

Broncho Pneumonia

(Duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) E. E. Nichols M. D.

June 5, 1924 (Address) Pikesville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral — DATE OF BURIAL, June 5, 1924

20-UNDERTAKER John J. Gillo — ADDRESS 1200 W Lombard

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 D 87580

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sisters of Mer 10 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Richard Shannon.

(a) Residence No.... Preston & Valley Sts. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married~~, Widowed, ~~or Divorced~~. (Write the word.) Widower

5a-If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Kate Johnson

6-DATE OF BIRTH (month, day and year) 4 Nov, 1862.

7-AGE, 61 yrs. 7 mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Andrew Shannon

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country),

12-MAIDEN NAME OF MOTHER, Bridget O'Hara

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country),

14-

(Informant)..Sister Florence.....

(Address)..Preston & Valley.....

15-

Filed ..... 192 ROBERT M. KRAUTER, Burial Permit Clerk.

JUN 5 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 3/24

17- I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to ....., 19.....

that I last saw h.m alive on ..... June 1 ....., 1924,

and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

June 4, 1924 (Signed) F. A. Warner, M. D. (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, June 5, 1924

20-UNDERTAKER, K. C. Middefeld — ADDRESS 934 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 87581

D 87581

CERTIFICATE OF DEATH

162

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 25 W Hamilton ave ST. WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert W. McShane

(Residence in Baltimore: No. 25 W Hamilton ave St.; ... yrs. ... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6-DATE OF BIRTH: June 1, 1924 (Month) (Day) (Year)

7-AGE: ... yrs. ... mos. 2 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: James A McShane

11-BIRTHPLACE OF FATHER (State or country): Balto

12-MAIDEN NAME OF MOTHER: Helen Finnegan

13-BIRTHPLACE OF MOTHER (State or country): Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Helen McShane

(Address) 25 Hamilton ave

15

JUN 5 - 1924

ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June 4th, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd, 1924 to June 4th 1924

that I saw h alive on June 4th 1924

and that death occurred on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Alcholuric Jaundice

(Duration) ... yrs. ... mos. 2 ds

Contributory (SECONDARY) Edanctosis

(Duration) ... yrs. ... mos. 1 ds.

(Signed) Howard E Brodrick M. D.

June 5th 1924 (Address) 20 Chatsworth

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral June 5

DATE OF BURIAL: .1924

20-UNDERTAKER: H. C. Wedefeld

ADDRESS: 914 Greenmount ave

6c—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87582

CERTIFICATE OF DEATH.

D 87582

1-PLACE OF DEATH

City of BALTIMORE: (No. 361 E. Streeper St., 6 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William H. Proudfoot

(a) Residence No. 361 E. Streeper St., 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-if married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug-1861

7-AGE. 63 yrs. 10 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Odd

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Wm. H. Proudfoot

11-BIRTHPLACE OF FATHER (city or town) (State or Country). City

12-MAIDEN NAME OF MOTHER. Mary Flashell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). City

14- (Informant) Annie Proudfoot

(Address) 361 E. Streeper St.

15- Filed JUN 5 - 1924 Robert R. Krauter, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 3 1924

17- I HEREBY CERTIFY, That I attended deceased from May 25, 1924 to June 3, 1924

that I last saw h.m alive on June 2, 1924

and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C.

(Signed) John J. O'Connor M. D.

June 3, 1924 (Address) 35-4 Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL, June 6th, 1924

20-UNDERTAKER. J. A. Moran — ADDRESS 3000 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143 D 87583

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1640 E. Eager ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah A Gerlach

(a) RESIDENCE NO. 1640 E Eager St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female /White/	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Gerlach

6 DATE OF BIRTH (month, day, and year) Feb 4/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm WOODEN

11 BIRTHPLACE OF FATHER (city or town) (State or conntry) Balto. Md

12 MAIDEN NAME OF MOTHER Capitolia Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Rose Eiler
(Address) 805 N. Eden St

15 Filed JUN 5 - 1924 ALBERT S. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ner death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sepsis-Possible Ectopic Gestation
(Pus in abdomen) Rt Tube

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature] (Coroner.) M. D.

June 5/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	June 192
20 UNDERTAKER Funkler Funkler	ADDRESS Eager

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87584

D 87584

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., V WARD)

2-FULL NAME Mrs. Rebecca Katz

(a) RESIDENCE NO. 1929 E. Pratt ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Katz

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Charnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gertrude Charnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 FILED JUN 5 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1923, to June 4, 1924,

that I last saw h.. alive on June 4, 1924,

and that death occurred, on the date stated above, at 1:10 p m.

The CAUSE OF DEATH* was as follows:

myocarditis with aortic and mitral insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor I. Jury M. D.

June 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/5 1924

20 UNDERTAKER Jack Lewis 1439 E Balt

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-1021 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87585

CERTIFICATE OF DEATH.

154-002 D 87585

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 15 WARD)

2-FULL NAME Baby Shulman

(a) RESIDENCE NO. 160 N Broadway ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 11 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Louis Shulman

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Rae Beck

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant .....
(Address) Hosp

15 Filed JUN 5 - 1924 ROBERT L. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 2, 1924,

that I last saw h[illegible] alive on June 2, 1924,

and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure following operation

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Isidore L. Fury M. D.

June, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosh Pd

DATE OF BURIAL 6/5 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1429 E Balto St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 87586

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87586

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Hollins Ra ST.: Penn Gdns. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant daughter Vernon & Ruth Kunsler

(a) RESIDENCE. NO. 621 Hollins Ra ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 4/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				11 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Vernon Kunsler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ruth E Glomms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Vernon Kunsler
(Address) 621 Hollins Ra

15 Filed JUN 5 1924 19 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to June 4, 1924

that I last saw h alive on June 4, 1924

and that death occurred, on the date stated above, at ~~4:30~~ 11 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Alvin B Lunsman M. D.

, 19 (Address) 1 W Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 6/5 1924

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87587 **CERTIFICATE OF DEATH.** 100-001 D 87587

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Duncan

(a) RESIDENCE NO. Bay View Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 JUN 5 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 1 1924

17 I HEREBY CERTIFY, That I attended deceased from 4 - 15, 1924, to 6 - 1, 1924, that I last saw her alive on 6 - 1, 1924, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ext.

(Signed) Claude C. Dunn, M. D.

6-2, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 1924
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87588

181-98 D 87588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 James ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nora J. Browning

(a) RESIDENCE NO 1229 James ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J. Browning

6 DATE OF BIRTH (month, day, and year) June 5th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. F. Crawford

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna Ward

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Wm J Browning
(Address) 1229 James St

15 Filed JUN 5 - 1924 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Insert "autopsy" or "inquest" or "inquiry.")
thereon and from the evidence obtained by said Inquiry
(Insert "autopsy" or "inquest" or "inquiry.") find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Asphyxiation by Illuminating Gas
Dec'd when found

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Loose Gas Jet

(Duration) yrs. mos. ds.

(Signed) Thos. R. Norton, M. D.
(Coroner)

June 4th, 1924 (Address) [illegible]

*State the Disease Causing Death, giving the Primary Cause, Secondary Causes, Complications, if any, which Contributed to Death. In violent cases, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 6, 1924

20 UNDERTAKER: [illegible] — ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87589 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87589

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2036 E. Biddle ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Wisbeck

(a) RESIDENCE NO. 2036 E. Biddle ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868 - May 28

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56		5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife 07
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Philip Smith

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Schweitzer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant John Wisbeck
(Address) 2036 E Biddle St

15 Filed JUN 5 - 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1924, to June 2nd, 1924, that I last saw h[er] alive on June 2nd, 1924, and that death occurred, on the date stated above, at 11 20 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis, Myocardial Degeneration, Benign Hypertension

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A. T. Reis, M. D.

June, 1924 (Address) 24 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 6 1924
20 UNDERTAKER	**ADDRESS**
Stephen J Frankowski	1001 Glenwood Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87590

CERTIFICATE OF DEATH.

74 B 87590

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 208 N. Streets ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. Brown

(a) RESIDENCE NO. 208 N. Streets ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Brown

6 DATE OF BIRTH (month, day, and year) Dec 1, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamboat 074

(b) General nature of industry, business, or establishment in which employed (or employer) Freight ships

(c) Name of employer Emerson Line (Kent Co md)

9 BIRTHPLACE (city or town) (State or country) (Kent Co md)

PARENTS

10 NAME OF FATHER ? Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) (Kent Co md)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (Kent Co md)

14 Informant Lewis Brown (Son)

(Address) 208 N. Streets

15 Filed JUN 5 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1924. to June 2, 1924.

that I last saw him alive on June 2, 1924.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ch. Kidney Nephritis

(duration) 7 yrs. 9 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Walter Love & Son, M. D.

, 19 (Address) 16 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL June 7 1924

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 197

D 87591

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Thos McWilley

(a) RESIDENCE NO. 706 Banks St. Salisbury Md. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	single?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Circus

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknwn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James Hodges
(Address) Trunk Wm Shoes
To Bill Bowe - Cincinnati

15 Filed ..... 1924 ROBERT R. KRAUTER, Registrar
JUN 5 - 1924
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot thru heart By Harry Evans

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Collins, M. D.
(Coroner.)
June 5/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury N. C.	June 5 d 1924
20 UNDERTAKER A. Jones	ADDRESS W. L. Gibson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Pks.

D 87592

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87592

CERTIFICATE OF DEATH.

74-007

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 428 N. Broadway St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T. Claus

(a) Residence No. 428 N. Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edward C. Claus

6-DATE OF BIRTH (month, day and year) June 4, 1846

7-AGE.			If LESS than 1 day,
77 yrs.	11 mos.	29 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Bartholomew Murphy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Cullen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Miss Florence Claus

(Address) 428 N. Broadway

15- JUN5 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 3/24

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924, to June 3 1924, that I last saw h. alive on June 3 1924, and that death occurred, on the date stated above, at 7.30 P. m. The CAUSE OF DEATH* was as follows:

General Arterio-sclerosis

unknown (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(Duration) ... yrs. mos. 20 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D

June 4, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cathedral Cemetery	6/6 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	305 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87593

CERTIFICATE OF DEATH.

t 188 003 ✓ D 87593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rene Fauteselle

(a) RESIDENCE NO. Syracuse N. Y. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	23	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chef
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) France
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) France
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant F. Lebeau
(Address) 119 No. 47th st. New York

15 Filed JUN 5 - 1924 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Internal Hemorrhage

(duration) 4 yrs. 6 mos. 2 ds.

CONTRIBUTORY (Secondary) Ran into motorcycle into automobile

(duration) yrs. mos. ds.

(Signed) Robt. B. Horton, M. D.
(Corner.)

June 4 1924 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A & Co	June 5 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 87594

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Lindenhall ST. 27 WARD)

2-FULL NAME Lizzie Long

(a) RESIDENCE NO. 627 Lindenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Long

6 DATE OF BIRTH (month, day, and year): Jan 6th 1885

7 AGE: Years 39 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Do "

PARENTS

10 NAME OF FATHER: Matt Strayhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do "

12 MAIDEN NAME OF MOTHER: Adney Craghorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant: Mrs. Lizzie Long

(Address) 627 Lindenhall St.

JUN 5 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1924, to June 4th, 1924, that I last saw h alive on June 3rd, 1924, and that death occurred, on the date stated above, at 7'39 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Shock No attendant

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elzi M. D.

June 6, 1924 (Address) 527 Lindenhall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: June 6 1924

20 UNDERTAKER: H. L. Dromgold Son — ADDRESS: 108 N. Mount St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3768 Morley St. St., N Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary E Harford

(a) Residence No. 3768 Morley St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank A. Harford

6-DATE OF BIRTH (month, day and year) Feb 13, 1888

7-AGE, 36 yrs. 4 mos. 21 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At Home

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER John J. Sorgler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Wash. D C

12-MAIDEN NAME OF MOTHER Agnes Tischer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Europe

14-(Informant). Frank A. Harford

(Address) 3768 Morley St

15-Filed JUN 5 - 1924 Robert F. Carrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-4-24

17-I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to June 4, 1924, that I last saw h.. alive on June 2, 1924, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows: Pulmonary and Laryngeal Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Laboratory report

(Signed) M. D.

6/5, 1924 (Address) 1405 EDMONDSON AVE.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral

DATE OF BURIAL. June 7, 1924

20-UNDERTAKER. Wm Cook

ADDRESS 502 E Hoffman

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87596

CERTIFICATE OF DEATH.

D 87596

1-PLACE OF DEATH

City of BALTIMORE: (No. 1945 W. Mulberry St., 70 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Josiah S Rivers

(a) Residence No. 1945 W Mulberry St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah S Rivers

6-DATE OF BIRTH (month, day and year) May 11 1853

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Plaster

(b) General nature of industry, business, or establishment in which employed (or employer)... None

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country) Philadelphia Pa

PARENTS.

10-NAME OF FATHER, Howell S Rivers

11-BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey

12-MAIDEN NAME OF MOTHER, Margaret A Leary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14- (Informant) Mary E Wagner

(Address) 1945 W. Mulberry St

15- Filed JUN 3 - 1924 Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 5 24

17- I HEREBY CERTIFY, That I attended deceased from June 2nd, 19..., to June 5, 19 24, that I last saw h[illegible] alive on June 4, 19..., and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

June 5, 1924 (Signed) Guy D. Williams, M. D. (Address) 400 N. Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore Cemetery	June 8, 1924
20-UNDERTAKER,	ADDRESS
Williams Cook & Walsh Co	522 E Saratoga

A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—THIS IS A P

Spec.—1-10-21—M&T—1500 Bks.

D 87597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87597

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Haines

(a) RESIDENCE No. 1708 N. Payson ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W Haines

6 DATE OF BIRTH (month, day, and year) July 26 59

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Leonard Gile

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Stevenson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant John W Haines

(Address) 1708 N Payson

15 Filed JUN 5 - 1924, 19 ..... Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-12, 1924, to 6-4, 1924, that I last saw h alive on 6-4, 1924, and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

6

?, (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John C. Weber M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Md

DATE OF BURIAL June 7 1924

20 UNDERTAKER W. M. Routson

ADDRESS 2238 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87598

CERTIFICATE OF DEATH.

D 87598

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1445 N. Carey St. ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nannie T. Stanton,

(a) RESIDENCE NO. Alpha, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Schuyler Stanton

6 DATE OF BIRTH (month, day, and year) June 9, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53 Yrs.	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER James Lavar.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Marcellus E. Toney,

(Address) 1445 N. Carey St.

15 Robert F. Harrison, Registrar

Burial Permit Clerk.

UN5 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 28th, 1924, to June 4, 1924,

that I last saw her alive on June 4th, 1924,

and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstatial Nephritis.

Not Known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Alpha, Va.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Harry F. Brown, M. D.

6/4, 1924 (Address) 1501 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alpha, Va. DATE OF BURIAL: June 5th 1924

20 UNDERTAKER: Thomas E. Wright ADDRESS: 1646 W. Cary

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 87599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 D 87599

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 N Carlton St.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Ipes

(a) RESIDENCE. NO. 521 N Carlton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E Ipes

6 DATE OF BIRTH (month, day, and year) March 4 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Thomas E Ipes. 521 N Carlton

15 Filed 19 Robert F. Harrison Registrar

JUN 5 - 1924

Burial Permit Quick.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1924, to June 3 1924, that I last saw h alive on June 2 19..., and that death occurred, on the date stated above, at 10 Pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis 2

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) H Kim Tilley, M. D.

, 19 (Address) 2838 Jack

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 6/6 19

20 UNDERTAKER Martin W & Duffield — ADDRESS 37

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

D 87600 ✓

12206

HEALTH DEPARTMENT—CITY OF BALTIMORE D 87600

CERTIFICATE OF DEATH.

X23

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Everett

(a) RESIDENCE NO. Forest Hill Hospital ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 15 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) .....

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 11 1922

7 AGE — Years 1 Months 8 Days 25 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chester Everett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hazel Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 5 - 1924 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to June 6, 1924, that I last saw her alive on June 6, 1924, and that death occurred, on the date stated above, at 7 00 a. m.

The CAUSE OF DEATH* was as follows:

Acute epidemic encephalitis

(duration) ..... yrs. ..... mos 20 ds.

CONTRIBUTORY (Secondary) ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. A. Reed, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Hill Md. | DATE OF BURIAL 6-7 1924

20 UNDERTAKER E. C. Kurtz & Son | ADDRESS Jarrettsville Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87601

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 87601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 14 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Wilson

(a) RESIDENCE. No. 1434 McCulloh St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C

PARENTS

10 NAME OF FATHER Andrew Coulbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Municipal Hospital Records

15 Filed 6-25-1924 Robert P. Harrison, Registrar

Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-1924

17

I HEREBY CERTIFY, That I attended deceased from 5-22, 1924, to 6-5, 1924

that I last saw h[illegible] alive on 6-4, 1924,

and that death occurred, on the date stated above, at 10:5 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Hypertension
Chronic Nephritis; Myocardial

Insufficiency (duration) yrs. 6 (Autopsy)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sat. + Autopsy

(Signed) Claude S. Grace, M. D.

6-5, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	6/7/1924

20 UNDERTAKER Helen A. Holland ADDRESS 1631 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Durbin Parks)

D 87602

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87602

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE: (No. Buck's Lane & ly n. R.R. ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Durbin Parks

(a) RESIDENCE NO. Buck's Lane & Western Md R.R. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER J. P. B. Parks,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Katherine Myskow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Howard Parks,
(Address) Buck's Lane & W.M. R.R.

15 Filed JUN 5 - 1924 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-3-1924

17

I HEREBY CERTIFY, That I attended deceased from 6-2, 1924, to 6-3, 1924,

that I last saw him alive on 6-3, 1924,

and that death occurred, on the date stated above, at 1.00 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis,
Cerebral hemorrhage

(duration) 2 yrs.? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 24 mos. hrs. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Henry Russell M. D.

6/4. 1924 (Address) 3902 Roseland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sater's Cemetery

DATE OF BURIAL June 6, 1924

20 UNDERTAKER E. LeRoy Stifflen

ADDRESS 125 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

N5 - 1924

Spec. 1-10-21—M&T—1500 Blks.

D 87603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 87603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. ST., 19 WARD)

2-FULL NAME Mrs Amanda Kauffman

(a) RESIDENCE No. 1305 W Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Winfield Kauffman

6 DATE OF BIRTH (month, day, and year) Dec. - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (All)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lititz Pa
(State or country)

PARENTS

10 NAME OF FATHER George Empfield

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant James B Kauffman
(Address) 1305 W Baltimore St

15 Filed JUN 5 1924 Robert F. Harrison.
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-26, 1924, to 6-5, 1924,

that I last saw her alive on 6-5, 1924,

and that death occurred, on the date stated above, at 9 25 a m.

The CAUSE OF DEATH* was as follows:

Chronic Polycystic Liver

Cirr. Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure - Pulmonary Edema 2 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lititz Pa	June 6 1924
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 87604

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87604

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Beneze

(a) RESIDENCE NO. 616 S. East Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Beneze

6 DATE OF BIRTH (month, day, and year) Sept. 2. 1838

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watch. maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records (Address)

15 Filed 1924 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 5 - 1924

17 I HEREBY CERTIFY, That I attended deceased from 5 - 15 - 1924 to 6 - 5 - 1924

that I last saw him alive on 6 - 4 - 1924

and that death occurred, on the date stated above, at 1.00 p. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Davis, M. D.

6-5, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 7 1924
20 UNDERTAKER Mrs. Mrs. John M. Teufel & Son	ADDRESS 801 W. Fayette

WARNING—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87605

CERTIFICATE OF DEATH.

D 87605

24431

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 E. Randall St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry R. Westinghausen

(a) Residence No. 114 E. Randall St., ... Ward .....
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Alma A. Westinghausen

6-DATE OF BIRTH (month, day and year) Sept 10 1895

7-AGE. 28 yrs. 8 mos. 29 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stock Dept.

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R. Co

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Louis Westinghausen

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Pauline Lang

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mrs Alma A Westinghausen

(Address) 114 E. Randall St

15-

Filed ..... 192. Robert E. Harris

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 3 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to June 3 1924

that I last saw him alive on June 3 1924

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 15 Minutes

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) ..... yrs. 3 mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ..... M. D

6/7. 1924 (Address) 1 E. Randall St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul's Cem

DATE OF BURIAL: June 5 1924

20-UNDERTAKER: Wm J Luckner Sons

ADDRESS Govans Md

N5 - 1924 Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87606

CERTIFICATE OF DEATH.

46 D 87606

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 Hulmer ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Parker

(a) RESIDENCE NO. 1028 Hulmer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Parker

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jos Jefferson Hornsby

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alfred Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Albert Parker

(Address) 1028 Hulmer

15 Filed JUN 6 1924 ROBERT H. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 4 1924

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to Jun 4, 1924.

that I last saw her alive on Jun 3, 1924

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) William E Burton M. D.

6/4, 1924 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 6 1924

20 UNDERTAKER John H. Toadvine ADDRESS 142 Westfield St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87607

CERTIFICATE OF DEATH.

129 D 87607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 n. Spring ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Smith

(a) RESIDENCE NO. 608 n. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE — Years: 59 — Months — Days — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER: arthur Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: alice Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: arthur Smith

(Address): 608 N Spring St

15 Filed: JUN 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4-1924

17 I HEREBY CERTIFY, That I attended deceased from 2-2-1924, to 6-4-1924, that I last saw h~~e~~r alive on 6-3-1924, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulete

(duration) Indefinate yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis

(duration) Indefinate yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6-5-1924 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery

DATE OF BURIAL: 6/6/24 19

UNDERTAKER: R B Gross

ADDRESS: 1405 McElderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87608

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucille Cluster

(a) RESIDENCE NO. 3720 Woodland ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? 29 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER David Cluster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Rose Cluster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Max Miller

(Address) 3726 Woodlawn Ave

15 Filed JUN 6 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 5, 1924, that I last saw h.. alive on June 5, 1924, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chr. nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor L. Jaffe, M. D.

June 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave — DATE OF BURIAL: 6/6 1924

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87609

CERTIFICATE OF DEATH.

16 90

D/87609

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2430 Edmondson St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline E. McShane

(a) Residence No. 2430 Edmondson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of H. Karlton McShane

6-DATE OF BIRTH (month, day and year) Oct 9 1893.

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm M Tice

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Pauline B Eggner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) H. Karlton McShane

(Address) 2430 Edmondson

15- JUN 6 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4-1924

17- I HEREBY CERTIFY, That I attended deceased from Oct 21, 1923 to June 4, 1924, that I last saw h[illegible] alive on June 4, 1924, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Chronic Myocarditis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation with [illegible] Edema (Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Robert E. Lee Hall M. D.

June 5, 1924 (Address) 2112 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL, June 6, 1924

20-UNDERTAKER: John O Mitchell — ADDRESS: Gay & Fayette 2112 Md Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87610 CERTIFICATE OF DEATH. 161-001 D 87610

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 502 Retreat ST., 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Chenoweth

(a) RESIDENCE No. 502 Retreat ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	WHT	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) 502 Retreat St
(State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edw. Chenoweth

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Paulsen

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Edw. Chenoweth
(Address) 502 Retreat St

15 Filed JUN 6 - 1924 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to June 4, 1924,

that I last saw h[illegible] alive on June 4, 1924

and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Premature.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) E A Schmick, M. D.

6 5, 1924 (Address) 1605 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUN 5 - 1924
20 UNDERTAKER	ADDRESS
[illegible] Health	

Per. Wm. E. Woodall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Blks.

This undaimed body is at Mercy Hospital Morgue Coroner locate any relatives & get any information about him

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87611

CERTIFICATE OF DEATH.

188-00 D 87611

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME August Muller

(a) RESIDENCE No Dont Know ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant ..... (Address) Dont Know

15 Filed ..... 192 ..... Registrar

JUN 6 - 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

fractured Spine + shock

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Struck by automobile

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Founds, M. D.
(Coroner.)

6-4 . 192 4 (Address) 1179 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS JUN 5 - 192

Per Wm. R. Woodall

CAUSE OF DEATH is very important. See instructions on back of certificate. TION should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPA-

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-3-19—H. P. Co.—1000 Bks.

D 87612

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 87612

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sandy Prophet

(a) RESIDENCE. No. 445 E. 23rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Prophet

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Eliza Prophet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Virginia

14 Informant Municipal Hospital Records (Address)

15 Filed JUN 6 - 1924 19... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 3 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-21, 1924, to 6-3, 1924

that I last saw ~~him~~ alive on 6-3, 1924

and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 7 yrs. mos. ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude G. Drane, M. D

6-4 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Va	June 6 1924

20 UNDERTAKER Mac. R. C. Elliott ADDRESS 1725 Eastlander

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87613

198 D 87613

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. Pronounded dead St. St. Joseph Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Thomas

(a) RESIDENCE No 1032 N. Wolfe St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unk yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of xxxxx

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	About 30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Maggie Robinson (Address) 1032 N Wolfe St

15 Filed JUNE 6 1924 ROBERT B. KRAUTER Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage rt. lung

Stabbedby John Miller

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. Pace (Coroner.), M. D.

June 5, 24 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 6 1924
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 127 Eastland Av

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 87614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine Wehland

(a) RESIDENCE No. Ilchester, Howard Co. ST., WARD Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 hours How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman D. Wehland

6 DATE OF BIRTH (month, day, and year) Nov 7 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER — Diefenbach

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Information given by Mr. Wehland
(Address) Ilchester Md

15 JUN 6 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Body & face burned

(duration) yrs. 12 hrs. ds.

CONTRIBUTORY (Secondary) Coal Oil can exploded setting fire to clothing

(duration) yrs. ds.

(Signed) Thos B. Horton M. D.
(Coroner)

June 4, 1924 (Address) Custer Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 7 1924
20 UNDERTAKER	ADDRESS
Scott M. Starr	Ellicott City Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 87615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Fait ave ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Richards

(a) RESIDENCE NO. 3500 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles H. Richards

6 DATE OF BIRTH (month, day, and year) April 25-1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Emanuel Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Lekendy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles H. Richards

(Address) 3500 Fait ave

Filed JUN 6 - 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to June 4, 1924,

that I last saw h W alive on June 4, 1924,

and that death occurred, on the date stated above, at 11.19 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) CA Reifschneider, M. D.

6/5, 1924 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL June 7 1924

20 UNDERTAKER Zinkler + Zinkler — ADDRESS 1737 E Lage

2 B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 87616 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 90 D 87616

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2100 East Balto St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Yochelt

(a) Residence No. 2100 E Balto St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Yochelt

6-DATE OF BIRTH (month, day and year)

7-AGE 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER Chain Pressman

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER Leah —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14-(Informant) Abram Pressman

(Address) 1921 E Fayette St

15-JUN 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/5/24

17- I HEREBY CERTIFY, That I attended deceased from Jan. 19 22 to June 5 19 24

that I last saw h. alive on June 5th 19 24

and that death occurred, on the date stated above, at 4 0 m.

The CAUSE OF DEATH* was as follows:

Hypochondriacal Suffering

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. Stone M. D

6-6- 19 24 (Address) 1810 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Hebron Rosedale	6-6- 19 24
20-UNDERTAKER. Jack Lewis	ADDRESS 1421 E Balto

R. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87617

HEALTH DEPARTMENT—CITY OF BALTIMORE

1881 D 87617

CERTIFICATE OF DEATH.

1-PLACE OF DEATH On way to University Hospital

CITY OF BALTIMORE. (No. Belvedeir Cadley ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jno C. Saffington

(a) RESIDENCE No. 1907 Edmondson St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 14 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work R.R. Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B&O R.R. Co 073

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jno C Saffington

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Ella Saffington
(Address) 1907 Edmondson Ave

15 Filed JUN 6 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 3- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest, au-~~ ..... find that said deceased came to his death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull, Fractured Clavicle Left Leg & Shock

(duration) 4 Hours minutes ds.

CONTRIBUTORY (Secondary) Struck by B&O R.R. Train

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W B Purnell M. D.
(Coroner.)

6-6, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 6 1924
20 UNDERTAKER	ADDRESS
John J Corwan & Son	901 Hollins St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87618

CERTIFICATE OF DEATH.

11 D 87618

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1615 Westwood Avenue (Ward) 15

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wade Taylor

(a) RESIDENCE. No. 1615 Westwood Avenue St.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~) of Blodwyn Taylor

6 DATE OF BIRTH (month, day, and year) April 9th 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commercial 045

(b) General nature of industry, business, or establishment in which employed (or employer) Bradley Eggs

(c) Name of employer T. E. Parkinson Co

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Geo A. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Margaret Pigott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stenbenville Ohio

14 Informant Rosalie Keller (Address) 319 Fairmount Road Jersey City

15 Filed JUN 6 - 1924 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1924

17

I HEREBY CERTIFY, That I attended deceased from June 4th, 1924, to June 4th, 1924, that I last saw h.. alive on June 4th, 1924, and that death occurred, on the date stated above, at 1148 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis (Fermentation in Stomach of indigested food) (duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation (duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm J Sullivan, M. D

(Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jersey City N J	June 7th 1924
20 UNDERTAKER	ADDRESS
Josiah Lyford	1600 Wasarth Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87619

CERTIFICATE OF DEATH.

129 D 87619

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 S. Collington Av. ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Annie Gordy.

(a) RESIDENCE NO. 226 S. Collington Av. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William P. Gordy

6 DATE OF BIRTH (month, day, and year) June 25th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Holland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Egleston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie L. Gordy

(Address) 226 S. Collington Ave.

15 Filed JUN 6 - 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1924

17

I HEREBY CERTIFY, That I attended deceased from January 22, 1924, to June 4, 1924.

that I last saw h.l.v. alive on June 4, 1924,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis,

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No,

(Signed) Hugh Forsythe, M. D.

, 19 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 6 1924
20 UNDERTAKER E. Schlosman & Son	ADDRESS 1024 Hanover St.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87620

CERTIFICATE OF DEATH.

5/ D 87620

REGISTERED NO.....

(If death occurred in n hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Hanover St. ST., 23 WARD)

2-FULL NAME Lola C. Feig.

(a) RESIDENCE No. 2000 Hanover St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, ~~widowed~~ ~~divorced~~ (or) WIFE of Norman F. Feig.

6 DATE OF BIRTH (month, day, and year) October 20, 1903.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George E. Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sandy Hook Md.

12 MAIDEN NAME OF MOTHER Augusta Ludwitzke.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Norman F. Feig. (husband)
(Address) 2000 Hanover St.

15 JUN 6 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd. 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis.
(9 mos. Pregnant)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jun. 4th. 192 4 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	June 6 1924
20 UNDERTAKER	ADDRESS
A. Howard Evans	38 E. Fayette

MEDICAL PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002

109 D 87621

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Kent

(a) RESIDENCE NO. 2424 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) Feb 22, 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Roland Kent.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ruth Johnson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Ruth Kent.
(Address) 2424 Stockton st

15 Filed JUNE 6 1924 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1924, to June 4, 1924,

that I last saw her alive on June 3, 1924,

and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency
Pericarditis with effusion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2424 Stockton St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Evidence - X-ray

(Signed) [illegible], M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemtery	June 7, 1924
20 UNDERTAKER Musgao H. Dennis Jr. per J. E. Nelson.	ADDRESS 1303 Preston St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87622

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 87622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 364 St Helena Ave St., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanie Robertson

(a) RESIDENCE No. 364 St Helena Ave St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Robertson

6 DATE OF BIRTH (month, day, and year) Aug 7 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER John Agnew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Earl F Tucker

(Address) 364 St Helena Ave

15 JUN 6 - 1924 19.. ROBERT A. KRAETZER Registrar

Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to June 4, 1924, that I last saw her alive on June 4, 1924, and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Cormone, M. D.

, 19 (Address) Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 7 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

87623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 1 001 ✓ D 87623

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 20 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Henrietta Wilson

(a) RESIDENCE NO. 2102 Boyd street ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 26, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Joseph Wilson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma Herring

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Joseph Wilson
(Address) 2102 Boyd St.

15 Filed JUN 6 - 1924 19 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1924, to June 6, 1924,
that I last saw h[illegible] alive on June 5, 1924,
and that death occurred, on the date stated above, at 4.20 A.m.
The CAUSE OF DEATH* was as follows:

Premature

(duration) ..... yrs. 2 mos 11 ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) ..... yrs. — mos. 11 ds.

18 Where was disease contracted if not at place of death? Premature

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jay Mathis, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 7 1924

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

See affadivit on file June 9th 1924 ✓

D 87624

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 174 D 87624

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Vento (Marie Vento)

(a) RESIDENCE NO. Los Angeles Cal ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	65	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Domenico Greco

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Domenica Greco

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Joe Vento
(Address) 838 Locust Philadelphia

15 Filed ..... 192 ROBERT R. KRAUTER, Registrar
JUN 6 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Injured from Moving R R Train

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gonce, M. D.
(Coroner.)

6-6- 192 4 (Address) 117 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philla Pa	6/7 192 4
20 UNDERTAKER	ADDRESS
Jones & Tulson	12 N. Green St

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST. N WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Holzenbach

(a) RESIDENCE NO. 2041 Frederick Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. — mos. —

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) July 28, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Hergand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas Holzenbach

(Address) 2041 Frederick Ave

JUN6 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to June 4, 1924, that I last saw him alive on June 4, 1924, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Aaufman, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 1924
20 UNDERTAKER	ADDRESS
F. B. Heppid	1850 N Bond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Zimnoch

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 87626

CERTIFICATE OF DEATH.

90 D 87626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2541 Fait Av ST., 1 WARD)

2-FULL NAME Stanislaus Zimnoch

(a) RESIDENCE NO. 2541 Fait Av ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17-1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Tin Can Mfg.

(c) Name of employer Am. Can Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wojciech Zimnoch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Veronica Matkowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helen B. Zimnoch

(Address) 2541 Fait Av

15 Filed JUN 6 - 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1924, to June 4, 1924, that I last saw h[illegible] alive on June 4, 1924, and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease about (duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) about (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Chas. Keller M. D.

6-6 1924 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL June 9 - 1924

20 UNDERTAKER W. F. Sadowski. ADDRESS 705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-93 ✓ 87627

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Lancaster ST., 7 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth M Farren

(a) RESIDENCE No. 1808 Lancaster ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24/24.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Shepherd Farren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Kate Urbanski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Kate Farren.
(Address) 1808 Lancaster St

JUN 6 - 1924

ROBERT B. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5-24 8 AM 1924

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to June 5, 1924,

that I last saw h[illegible] alive on June 5, 19....,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bronchopneumonia following

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Burbage, M. D.

6/6, 1924 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	June 7 1924.
20 UNDERTAKER M. F. Sadowski.	ADDRESS 705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks. Naomi L. Necker

D 87628

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 11 4 D 87628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

City of BALTIMORE: (No. 20 St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi L. Necker

(a) Residence No. 2587 Dulaney St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 9, 1921

7-AGE.	If LESS than 1 day.
2 yrs. 10 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto Md.
(State or Country)

PARENTS.

10-NAME OF FATHER, Charles J. Necker

11-BIRTHPLACE OF FATHER (city or town) Md.
(State or Country)

12-MAIDEN NAME OF MOTHER, Lillian L. Rice

13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country)

14- (Informant) Charles J. Necker

(Address) 2587 Dulaney St.

15- Filed JUN 6 - 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4 1924

17- I HEREBY CERTIFY, That I attended deceased from June 3 19..., to June 4 19..., that I last saw h... alive on June 4 19..., and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Intestinal Indigestion.

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Manlahan M. D.

6/6/24 (Address) 2211 Fullerton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ..... 19....
20-UNDERTAKER.	ADDRESS 1504 Lombard St.,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87629

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87629
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 212 S. Gilmor St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Leroy Brown

(a) Residence No. 212 S. Gilmor St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) DEC. 27. 1923

7-AGE, 1 yrs. 5 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Sylvester J. Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Carroll Co. Md.

12-MAIDEN NAME OF MOTHER, Rose Witz.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14-
(Informant) Sylvester J. Brown
(Address) 212 S. Gilmor St.

15-Filed JUN 6 - 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 3 1924

17- I HEREBY CERTIFY, That I attended deceased from May 14th, 19 24, to June 3, 19 24, that I last saw him alive on June 3rd, 19 24, and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Heart Clot

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. K. Nuckolo, M. D.

, 19 (Address) 130 S. Gilmor St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cemetery

DATE OF BURIAL. June 6, 19 24

20-UNDERTAKER. Henry H. Witz & Co.

ADDRESS 1531 W. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 87630

1-PLACE OF DEATH 1847 McHenry St.,

Registered No.....

City of BALTIMORE: (No. 1847 St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Towson

(a) Residence No. 1847 McHenry St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Franklin D. Towson

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, about 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unbrage

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Mrs. Charle

(Address) 1845 McHenry St.

15- Filed JUN 6 - 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6/3/24

17- I HEREBY CERTIFY, That I attended deceased from 3/1/24, 19..., to 6/3/24, 19..., that I last saw her alive on 6/3/24, 19..., and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Asthenia

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 4 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

6/5/24 19 (Address) 1302 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
West'n Cem.	June 6 '24

20-UNDERTAKER,	ADDRESS
Mary A. Wittke	1531 W. Lombard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87631

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Charles Arnold

(a) RESIDENCE No. Farnwell Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katie Arnold

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retouching Engr

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): D. C.

PARENTS

10 NAME OF FATHER Jackson Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER Lana Post

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant: Reed. (Address) JOHNS HOPKINS HOSPITAL

15 JUN 6 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1924

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1924, to June 5, 1924,

that I last saw h— alive on June 5 1924,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Abscess

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Pneumonia Abscess

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1st

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

, 19 (Address) J. H. Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lost Creek W. Va via Clarksburg. DATE OF BURIAL: June 6th 1924

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87632

CERTIFICATE OF DEATH.

101-001 ✓

D 87632

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 Argyle Ave ST.: 17 WARD)

2-FULL NAME Charles Alexander Wilson

(a) RESIDENCE. No. 1012 Argyle ave ST.,.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Wilson

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Merchandise

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Susie Wilson (Address) 1012 Argyle Ave

JUN 6 - 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-5- 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1924, to June 5 1924, that I last saw h[im] alive on June 5 1924, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 1012 Argyle ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jos Carpen, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 6-8 1924

20 UNDERTAKER: Horton A. Holland — ADDRESS: 1631 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87633

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87633

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1 S Conkling St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret H Bell

(a) Residence No. 1 S Conkling St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of the late James P Bell

6-DATE OF BIRTH (month, day and year) May - 1861

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work, House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Annapolis Md

PARENTS.

10-NAME OF FATHER, Thos H Parkinson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Annapolis Md

12-MAIDEN NAME OF MOTHER, Dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Annapolis Md

14- (Informant) Conkling D. Bell Jr

(Address) 1 S Conkling

15- Filed JUN 6 - 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6 - 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to June 5, 1924, that I last saw h.. alive on June 5, 1924, and that death occurred, on the date stated above, at 7 a m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & Tuberculin

(Signed) Frank Conkling M. D.

, 19 (Address) 1938 Bell

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount Cem. DATE OF BURIAL, June 9, 1924

20-UNDERTAKER, Robt J Johnson ADDRESS 1472 Pratt

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Pds.

17195 6
D 87634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87634

CERTIFICATE OF DEATH.

REGISTERED No. .....

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Chase

(a) RESIDENCE No. 232 N Gilmor St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER Chas. Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Rosie Boone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 6 1924 Robert P. Harrison, Registrar
Burial Permit Work.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to June 6, 1924.

that I last saw h~~e~~ alive on June 6, 1924.

and that death occurred, on the date stated above, at 2.05 a.m.

The CAUSE OF DEATH* was as follows:

Subacute nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stevens St. Stevens Md | DATE OF BURIAL June 6 1924

20 UNDERTAKER Edward Brylawski | ADDRESS 1631 21st

WRITING IN THIS SPACE RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D 87635

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87635

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Southern Hospital. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 2520 Greenmount Ave ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Jacobs Reed.

(Residence in Baltimore: No. Southern Hospital St.; 50 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	White	Single

6-DATE OF BIRTH, June 15, 1835.
(Month) (Day) (Year)

7-AGE, 88 yrs. 11 mos. 19 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seamstress Retired
(b) General nature of industry, business, or establishment in which employed (or employer): 069

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, John Reed

11-BIRTHPLACE OF FATHER (State or Country). Winchester Va

12-MAIDEN NAME OF MOTHER Sarah Reed

13-BIRTHPLACE OF MOTHER (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ewell

(Address) Southern Hospital

15- Robert P. Harrison,

Filed ....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1 1923, to June 4 1924, that I saw her alive on June 4 1924, and that death occurred, on the date stated above, at 11 00 a.m.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial disease

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Dudley P. Bowe M. D.

June 5, 1924 (Address) 904 N. Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. 8 mos. 3 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Baltimore — DATE OF BURIAL, June 7..., 1924

20-UNDERTAKER W. Cook — ADDRESS 502 E North Ave

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JUN - 1924

Spec—12-23-21—E.B.R.S.—400 Bks.

Saltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87636

74-99 V

D 87636

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2414 E Hoffman. St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosina K. Pleines.

(a) Residence No. 2414 E Hoffman. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Chas. Pleines.

6-DATE OF BIRTH (month, day and year) April 25 1846

7-AGE. 78 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS:

10-NAME OF FATHER, Michael Beck.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Not known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany.

11- (Informant) Miss Frances Pleines.

(Address) 2414 E Hoffman St

15- Filed JUN 6 1924 Robert P. Harrison, Registrar.

Mrs Ferd Gut.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4th 24

17- I HEREBY CERTIFY, That I attended deceased from May 31st 1924 to June 4th 1924 that I last saw h.. alive on June 3rd 1924 and that death occurred, on the date stated above, at 5 15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 5

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) C W Pleines M. D.

June 4, 1924 (Address) 1 W. E. Cay St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL, 6-7, 1924

20-UNDERTAKER M. E. Woodward & Robt. E. Woodward

ADDRESS 1200 W Lanvale St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87637

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87637

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3455 Ash St. St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Young

(a) Residence No. 3455 Ash St. St., 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Divorced

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben Young

6-DATE OF BIRTH (month, day and year) May 19-1847

7-AGE, 77 yrs. — mos. 17 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Thomas R. Scotton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Angelica Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-

(Informant) Miss Rhoda Enos

(Address) 3455 Ash St.

15-

Filed JUN 6 - 1924

Robert P. Harrison, M.D.

Registrar.

Buried Forest Cem.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 5-1924

17- I HEREBY CERTIFY, That I attended deceased from May 2nd, 19 24, to June 5, 19 24, that I last saw h. alive on June 5, 19 24, and that death occurred, on the date stated above, at 5:30 Am.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chron. Int. Nep.

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? None

What test confirmed diagnosis? Palpation Pulse Blood pressure

(Signed) Emma J. Kelly, M. D.

(Address) 5105 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Forest Cem. Windsor Hills — DATE OF BURIAL, June 7, 1924.

20-UNDERTAKER, Nolan A. Burgee — ADDRESS 3631 Falls Road

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87638

H-D 87638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Battery Ave ST.: 24th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Paul Schoebel

(a) RESIDENCE. NO. 1430 Battery Ave ST., 24th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white.	married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Irene Schoebel

6 DATE OF BIRTH (month, day, and year) July 7, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Horn & Horn.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Julius Schoebel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Pauline Kalk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Pauline Schoebel

(Address) 1430 Battery Ave.

15 Filed ....., 19.... Robert E. Norris

Registrar

UNG - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from October 6, 1923, to June 4, 1924

that I last saw him alive on June 4, 1924

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach.

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 27/1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry F. Buettner M. D.

, 19 (Address) 1243 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lakewood	June 7 1924
20 UNDERTAKER	ADDRESS
Wm Cook	522 E Fayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87639

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2644 Harlem Avenue St., 16 Ward)

Registered No. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Baldwin Huggins

(a) Residence No. 2644 Harlem Avenue St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 25, 1854

7-AGE: 69 yrs. 6 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9-BIRTHPLACE (city or town): Darlington (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: James Baldwin

11-BIRTHPLACE OF FATHER (city or town): Darlington (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah Forsythe

13-BIRTHPLACE OF MOTHER (city or town): Harford County (State or Country): Maryland

14- (Informant): Miss Neva S. Huggins

(Address): 2644 Harlem Avenue

15- Filed JUN 7 1924 By: Robert E. Lafferty Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4th, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 7, 19 24, to June 4, 19 24

that I last saw her alive on June 4, 19 24

and that death occurred, on the date stated above, at 11.50 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martin W. Stouch, M. D.

6-5, 1924 (Address) 806 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. DATE OF BURIAL, June 7, 1924

20-UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87640

CERTIFICATE OF DEATH.

8 90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 1245 North Broadway St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sarah E. Davis .....

(a) Residence No. 1245 North Broadway St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Davis

6-DATE OF BIRTH (month, day and year) Sept. 10th 1851

7-AGE, ... 72 yrs. 8 mos. 25 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).. Baltimore .....
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Solomon C. Wright

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Elizabeth A. Wilburn

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va.

14- (Informant)... Mr. E. Fuller Davis .....
(Address)..... 1245 North Broadway .....

15- Filed ..... Robert E. Lee, M. D., Registrar.

JUN 7 - 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June. 4th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to June 4, 1924, that I last saw h[illegible] alive on June 4, 1924, and that death occurred, on the date stated above, at 6.25 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

.....

.....

.....

.....(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No .....

What test confirmed diagnosis?.....

(Signed) Henry Hyde, M. D.

June 5, 1924 (Address) 1106 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Highland, Md. | DATE OF BURIAL, June 7, 1924

20-UNDERTAKER. Joseph B Cook | ADDRESS 1003 N. Bal[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—F.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87641

CERTIFICATE OF DEATH.

D 87641

1-PLACE OF DEATH

City of BALTIMORE: (No. 24 - E - 20th St. 12 Ward)

Registered No. 1460

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Jefferson

(a) Residence No. 24 - E - 20th St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fe

4-COLOR OR RACE, col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Leander Jefferson

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 32 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER, Julius Mendes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Cranie Braxton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Virginia

14- (Informant) Leander Jefferson

(Address) 24 E. 20th St. 10

15- Filed JUN 7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 4, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to June 4, 1924, that I last saw h.. alive on June 4, 1924 5:30 p.m. and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K. A. Johnson, M. D.

, 19 (Address) 211 - E - 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Auburn	June 7th, 1924
20-UNDERTAKER	ADDRESS
Joseph A Farrell & Son	2319 Division St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87642

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 721 S. Montford ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Kalet

(a) RESIDENCE NO. 721 S. Montford ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Kalet

6 DATE OF BIRTH (month, day, and year) June 20 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mr. Frank Kalet (Address) 721 S. Montford

15 JUN 7 - 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to June 6, 1924.

that I last saw ~~he~~ alive on 6 5, 1924.

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Val Dis. Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

6/6/24 (Signed) Chas Reese M. D.

(Address) 408 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL June 9 1924

20 UNDERTAKER Jos. J. Berr ADDRESS 156 N. Luzerne Ave.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87643

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87643

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Druid Hill Ave ST., 17 WARD)

2-FULL NAME Elizabeth Bruce

(a) RESIDENCE NO. 3120 Buckeye St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) about 1863 January

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook,
(b) General nature of industry, business, or establishment in which employed (or employer) Of
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Marteen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Grace Parrish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Miss Annie Marteen
(Address) 1208 Argyle Ave.

15 Filed JUN 1923, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart disease (Ord)

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

June 5, 1924 (Address) 2802 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loth Chapel Laws.	June 8 1924

20 UNDERTAKER Samuel S. Mousley ADDRESS 5[illegible] E Baltimore St.

NAME PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co. 1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87644

D 87644

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 235 N. Creston (St.) 11 (Ward)

2-FULL NAME Paul Green

(a) RESIDENCE. No. 235 N. Creston St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Green

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A A Co Md

PARENTS

10 NAME OF FATHER Nathan Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) A A Co Md

12 MAIDEN NAME OF MOTHER Mary Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co Md

14 Informant Leo Victor Johnson (Address) Ashton Balto Co Md

15 Filed JUN 7 - 1924

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to June 4, 1924

that I last saw her alive on June 4, 1924

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis about 4 ds.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Chemical

(Signed) Leo. H. Lautenbach, M. D.

6-4, 1924 (Address) 2215 N. Monroe Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	June 7 1924
20 UNDERTAKER	ADDRESS
Samuel Stanley	1128 Mott

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 D 87645

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Southern Hotel ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F. Gaitley

(a) RESIDENCE No. 1703 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Gaitley.

6 DATE OF BIRTH (month, day, and year) May 7- 86

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Goldsmith & Co.

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Ida Gaitley (Address) 1703 Holbrook

15 Filed JUN 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour) June 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above. The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot Wound.
(duration) yrs. mos ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

(Signed) Geo. Edwin Rodel, M. D.
(Coroner.)
6/6/24 192 (Address) 142 E. Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 7 1924
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E. Baltimore.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87646

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87646

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 646 Vine ST., 4 WARD)

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Flamer

(a) RESIDENCE NO. 646 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Octavia Flamer

6 DATE OF BIRTH (month, day, and year): March 20, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Denton Maryland

PARENTS

10 NAME OF FATHER: George Flamer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Cote

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Octavia Flamer 646 Vine St

15 JUN 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk's

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1924, to June 5, 1924

that I last saw him alive on June 5, 1924

and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Neville M. D.

6/6, 1924 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Exeter Md — DATE OF BURIAL: June 7, 24

20 UNDERTAKER: Sam H Chase Sons — ADDRESS: 1400 N Mon

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 87647

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1501 E. Eager St. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie. H. Seldner

(a) Residence No. 1501 E. Eager St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the Word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Samuel. W. Seldner

6-DATE OF BIRTH (month, day and year) Oct.-15-1861

7-AGE.	If LESS than 1 day.
62 yrs. 8 mos. 20 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md. (State or Country)

PARENTS

10-NAME OF FATHER, Lewis Hecht

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country)

12-MAIDEN NAME OF MOTHER Caroline Himmelrich

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Md.

14- (Informant) S. L. P. Seldner

(Address) 1501 E. Eager St.

15- Filed JUN 7 - 1924 Robert F. Harrison, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June-5-1924

17- I HEREBY CERTIFY, That I attended deceased from 4/20 19 24 to 6/5 19 24

that I last saw h[illegible] alive on 6/5 19 24

and that death occurred, on the date stated above, at 10:45 AM

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) arteriosclerosis & Chr. Myocarditis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D

6/6 19 24 (Address) 1526 E. Balto. St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore Hebrew Cemetery	June 9th 1924
20-UNDERTAKER. Henry Hock & Son	ADDRESS 1301 E. Eager

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87648

CERTIFICATE OF DEATH.

D 87648

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 W. Barre St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Auguste A. Seibert

(a) Residence No. 613 W. Barre St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jacob E. Seibert

6-DATE OF BIRTH (month, day and year) Nov 15 1838

7-AGE, 83 yrs. 6 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

10-NAME OF FATHER, John Eppler

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Catharine Hayden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-PARENTS.

(Informant) Charles E. Seibert

(Address) 613 W. Barre St.

15-Filed JUN 7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 6 1924

17-I HEREBY CERTIFY, That I attended deceased from Nov. 24 1923 to June 6 1924

that I last saw h.. alive on June 6 1924

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dellvett M. D

June 7 1924 (Address) 621 Washington Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cemetery	June 9 1924
20-UNDERTAKER, for Joerdens Son	ADDRESS 2178 Penn

(WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.)

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87649

CERTIFICATE OF DEATH.

101 D 87649

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 21 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Rice

(a) RESIDENCE. No. 1301 Glyndon Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) 834

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER George Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary Dambrauchas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Joseph Rice

(Address) 823 Hollins St.

15 Filed JUN 7 1924, 19 Robert P. Harris, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 5, 1924, that I last saw him alive on June 4, 1924, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Brodushas, M. D.

6-5-1924 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 9 1924

20 UNDERTAKER Chas. B. Kuchaurskas ADDRESS 637 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87650

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3606 Fairview Ave 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Greenwald

(a) Residence No. 3606 Fairview Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Greenwald

6-DATE OF BIRTH (month, day and year) June 25, 1869

7-AGE, 54 yrs. 11 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wolf Leopold

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-

(Informant) Isaac Greenwald

(Address) 3606 Fairview Ave

15-

Filed 1924 Robert F. Harrison, 192

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6/5/24.

17- I HEREBY CERTIFY, That I attended deceased from January, 1924, to June 5, 1924,

that I last saw her alive on June 5, 1924,

and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

carcinoma of ovary (primary)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) general carcinomatosis

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? Yes No Date of April 2. 24

Was there an autopsy?

What test confirmed diagnosis Clinical + laparotomy

(Signed) J. Frederick Lentz, M. D.

6-6, 1924 (Address) 7040 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Hebrew Friendship	6/9/, 1924
20-UNDERTAKER, David Sindheim	ADDRESS 118-20 W. Fayette Royal Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ON 7

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87651

CERTIFICATE OF DEATH.

D 87651

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., W WARD)

2-FULL NAME George C. Green

(a) RESIDENCE NO. Pennsylvania Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Green

6 DATE OF BIRTH (month, day, and year) Aug 3 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	38	10 mo		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ware

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Board.

15 Robert F. Barnes, ... 19 ..... Registrar

Burial Permit Clerk

JUN 7 - 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/24

17 I HEREBY CERTIFY, That I attended deceased from 6/3/24, 19..... to 6/5/24 19 .....

that I last saw h alive on 6/5/24 19

and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Stricture of Urethra with urinary extravasation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ? Pneumonia change

Did an operation precede death? Yes. Date of 6/3/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL June 10 1924

20 UNDERTAKER Mrs R A Elliott — ADDRESS Mrs R A Elliott 1725 Eutaw Pl

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87652

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1635 Lansing Ave St.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alberta J. Smith

(a) RESIDENCE. No. 1635 Lansing Ave. St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jay Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Hesler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Grace Burk
(Address) 1635 Lansing Ave

15 Filed JUN 7 1924 . 19 Robert P. Garrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1924

17

I HEREBY CERTIFY, That I attended deceased from May 5 . 19 24 . to June 1 . 19 24 ,
that I last saw h alive on June 6 . 19 24 .
and that death occurred, on the date stated above, at 2.05A m.
The CAUSE OF DEATH* was as follows:

Acute Toxic Enteritis

(duration) 1 yrs. mos. 7 ds

CONTRIBUTORY – (Secondary) Faulty Feeding

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Winfield M. D.

6/1 . 1924 (Address) 1279 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	June 11 1924
20 UNDERTAKER George J. Smith	ADDRESS 1332 Hollins

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87653

CERTIFICATE OF DEATH.

113

D 87653

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 425 S. Ballas ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Wielopolska

(a) RESIDENCE NO. 425 S. Ballas ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Wielopolska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berlo

12 MAIDEN NAME OF MOTHER Helen Meszynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Helen Meszynska
(Address) 425 S. Ballas

15 Filed JUN 7 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 6, 1924,

that I last saw her alive on June 6, 1924,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

June 7, 1924 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 6/8 1924

20 UNDERTAKER William Fiedkowski

ADDRESS 618 Eastern

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

GN7 - 1924

Spec.—1-10-21—M&T—1500 Bks.

D 87654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87654

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 E Fayette ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Creighton

(a) RESIDENCE NO. 1614 E Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Creighton

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster trade

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Cambridge, Maryland

PARENTS

10 NAME OF FATHER John Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Maryland

12 MAIDEN NAME OF MOTHER Mary Creighton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Maryland

14 Informant Arthur Creighton (Address) 1614 E Fayette St

15 Filed Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1924

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to June 5, 1924, that I last saw him alive on June 5, 1924, and that death occurred, on the date stated above, at 3.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

over

8 hrs (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bernard Harris, M. D.

, 19 (Address) 38 S Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 7 1924
20 UNDERTAKER	ADDRESS
Edward Bryson	Orleans

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 7 - 1924

Spec. 6-9-19—H. P. Co. 1000 Bks.

D 87655

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87655

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2209 Eutaw Pl (ST.) 13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mitchell Cross.

(a) RESIDENCE. No. 2209 Eutaw Pl St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced (or) WIFE of: Geo W Cross

6 DATE OF BIRTH (month, day, and year): Nov 28th 1848

7 AGE — Years: 75 — Months: 6 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Co Galway Ireland

PARENTS

10 NAME OF FATHER: John Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Co Galway Ireland

12 MAIDEN NAME OF MOTHER: Bridget Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Galway Ireland

14 Informant (Address): Mrs Jacob Meehan 2209 Eutaw Place

15 Filed JUN 7 1924 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from October 1st 1923. to June 6th 1924.

that I last saw her alive on June 6th 1924.

and that death occurred, on the date stated above, at 11:35 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) 7 yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Senile Gangrene (Toes of the right foot) (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Hypoglycist Clinical.

(Signed) William Sullivan, M. D.

1924 (Address) 1701 W. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: June 9 1924

20 UNDERTAKER: Martin Markey — ADDRESS: 847 W North.

INSTRUCTIONS.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87656

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87656

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Coolahan

(a) Residence No. 1403 Bloomingdale Rd St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1849

7-AGE. 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 648

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER Patrick Coolahan

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14-(Informant) Florence Coolahan

(Address) 1403 Bloomingdale Rd

15-Filed 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6- nt

17- I HEREBY CERTIFY, That I attended deceased from May 19 nt 19.., to June 6 19 nt, that I last saw h alive on June 6 19 nt, and that death occurred, on the date stated above, at 6 am m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Chronic Endocarditis ?)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? Phys Evidence.

(Signed) L Goldman M. D

, 19 (Address) St. Agnes Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL, June 7, 1924

20-UNDERTAKER, Martin Fahey Sons — ADDRESS 527 N North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN

Spec.—1-10-21—M&T—1500 Bks.

D 87657

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87657

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4729 Brightwood Ave ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mordon Thompson

(a) RESIDENCE NO. 4729 Brightwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. LIFE mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lula Frances Thompson

6 DATE OF BIRTH (month, day, and year) Sept. 3rd. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) Life Insurance

(c) Name of employer Metropolitan Life Ins.Co.

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Richard Thompson

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Jane Graves

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Miss Magdeline Thompson

(Address) 4729 Brightwood Ave.

15 Filed JUN 7 - 1924, 19 Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) M June 5 1924

17

I HEREBY CERTIFY, That I attended deceased from April 1st, 1924, to June 6th, 1924, that I last saw him alive on June 5th, 1924, and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Paranoia, manic depressive / Chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Smith M. D.

6/6. 1924 (Address) 4508 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid ridge Cemetery	6-9-24 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87658

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87658

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 W. York St. ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Stepney (C)

(a) RESIDENCE No. 9 W. York St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ---yrs.---mos. 19 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 16, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	----	---	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Frederick Stepney (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A. A. Co. Md

12 MAIDEN NAME OF MOTHER Luberta Pritchett (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) A. A. Co. Md.

14 Informant Luberta Stepney (C) mother.
(Address) 9 W. York St.

15 Filed JUN 7 - 1924 192 Robert P. Harrison, Registrar
Burial Permit clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
congenital.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

June 5, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	June 7 1924
20 UNDERTAKER	ADDRESS
Jno. Gerhardt & Sons	406 W. Conway St.

matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87659

CERTIFICATE OF DEATH.

90

D 87659

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 Madison Ave ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Caldwell Gray

(a) RESIDENCE NO. 1222 Madison Ave ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 77 yrs. 8 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Parkhurst Gray

6 DATE OF BIRTH (month, day, and year) Sept 16-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	77	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Chestertown Kent Co Md

PARENTS

10 NAME OF FATHER Maj. John Rodgers Gray

11 BIRTHPLACE OF FATHER (city or town) Wilmington

(State or country) Dela.

12 MAIDEN NAME OF MOTHER Anna Margaret Anderson

13 BIRTHPLACE OF MOTHER (city or town) Charleston

(State or country) W Va

14 Informant Ethel Rodgers Gray

(Address) 1222 Madison Ave

15 Filed ...-1924 ..., 19.. Robert P. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17

I HEREBY CERTIFY, That I attended deceased from May 29 1924, to June 6 1924.

that I last saw h alive on June 5 1924

and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar) Broncho 3 pneum

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Melvin S. Crandall, M. D.

, 19 (Address) 1222 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 7th 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. North Ave.

WARNING—RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 7

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 87660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87660

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1361 Andre St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Teodorczyk

(a) Residence No. 1361 Andre St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 19 1903

7-AGE. 21 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Adam . Teodorczyk

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Marcyanna Kazmierczyk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Adam. Teodorczyk (Father)
(Address) 1361 Andre Street

15- Filed ... 192.
Registrar.

Burial Permit Clerk

UN 7 -1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6 1924

17- I HEREBY CERTIFY, That I attended deceased from June 4th 19 24 to June 6 19 24
that I last saw h. in alive on ..... 19.....
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical —

(Signed) H. Leo Dunsford M. D

19 (Address) 1340 Eutaw

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (I) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 10....., 1924
20-UNDERTAKER,	ADDRESS
John A Weber	1803 Bank St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87661

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 Bank St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Fischer

(a) Residence No. 1410 Bank St., Ward.....

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. ~~Female~~

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of late John Fischer

6-DATE OF BIRTH (month, day and year) Sept 24/36

7-AGE. 87 yrs. 8 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Eckert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Louise Mulzer

(Address) 1410 Bank St.

15- Filed JUN 7 1924 19?

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 4/24

I HEREBY CERTIFY, That I attended deceased from May — 1914 to June 4 1924,

that I last saw ~~her~~ alive on June 3 — 1924

and that death occurred, on the date stated above, at 9 40 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Coma

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? —

What test confirmed diagnosis? Usual —

(Signed) Frank A Bruner M. D

June 7 — 1924 (Address) 125 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Schwartz's	6/7, 1924
20-UNDERTAKER.	**ADDRESS**
Philip Herwig	2016 Orleans St.

N. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

GB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87662

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 565 Prestman ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Not named~~ Baby Jackson

(a) RESIDENCE NO. 565 Prestman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-7-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 13 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Houston R. Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Marion Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Maryland

14 Informant Houston R. Jackson
(Address) 565 Prestman St

15 Filed JUN 7 1924, 19 Robert F. Berrigan, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 7th. 1924. to June 7th. 1924.
that I last saw h[illegible] alive on June 7th. 1924.
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prolapse Cord

(duration) yrs. mos. 10h ds.

18 Where was disease contracted if not at place of death? At place of birth

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lung tests

(Signed) W Grant Scott M. D.

. 19 (Address) 754 W Eddy St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	June 8 1924
20 UNDERTAKER	ADDRESS
Mrs Thos G. Bailey	142 Jefferson St

GN7 -1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87663

CERTIFICATE OF DEATH.

X 440 87663

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

2-FULL NAME Joseph Lawrence Whitlock

(a) RESIDENCE NO. Winchester, Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alma M. Whitlock

6 DATE OF BIRTH (month, day, and year) Oct 5th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0-25

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Clarence M. Whitlock

11 BIRTHPLACE OF FATHER (city or town) W. Va (State or country)

12 MAIDEN NAME OF MOTHER Lucy Alvarez

13 BIRTHPLACE OF MOTHER (city or town) W. Va (State or country)

14 Informant Hospital Record. (Address)

15 JUN 8 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-7th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1924, to June 7th 1924, that I last saw him alive on June 7th, 1924 and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 5, 1924

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) P B Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W. Va. DATE OF BURIAL 6-8 1924

20 UNDERTAKER E & B Hale ADDRESS 115 E Wash St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 87664

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1616 Hoffman St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret J. Sickal

(a) Residence No. 1616 Hoffman St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	M

5a-If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Jefferson M. Sickal

6-DATE OF BIRTH (month, day and year) Dec 17, 1863

7-AGE, 60 yrs. 5 mos. 20 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): 437
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, John McLaughlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, Margaret Lockery

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Jefferson M. Sickal
(Address) 1696 Hoffman

15- JUN 8 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6-24

17- I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to June 6th, 1924, that I last saw h[illegible] alive on June 6th, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W. White M.D.

6/6, 1924 (Address) 2800 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Parkwood	June 9, 1924
20-UNDERTAKER. Kirkler & Kirkler	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87665

CERTIFICATE OF DEATH.

31 D 87665

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Lee Fenner

(a) RESIDENCE. No. 200 S Oak ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Allen Fenner

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 8 - 1924 19

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 5 1924

17 I HEREBY CERTIFY, That I attended deceased from 5 - 31, 1924, to 6 - 5, 1924

that I last saw him alive on 6 - 5, 1924

and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis
Tuberculous Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab + Autopsy

(Signed) Claude S. Dean, M. D

6-6 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Mt Auburn. June 9 1924

20 UNDERTAKER ADDRESS

Clarence H. Wright 1300 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

D 87666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 87666

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leroy Bersterman

(a) RESIDENCE NO 920 Somerset St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) Feb 15/1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	3	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... child .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Bersterman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Josephine Kennedy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant George Bersterman
(Address) 920 Somerset St

15 Filed JUN 8 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over almost entire body
Accidental- Clothes caught fire
while playing with matches & kodak
film (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wallis, M. D.
(Coroner.)

June 6/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 9 192 4
20 UNDERTAKER	ADDRESS
George E. Ruth	1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87667 ✓ D 87667

D 87667

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 S. Eden St., ST., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Shapiro

(a) RESIDENCE NO. 126 S. Eden ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Katie Shapiro

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Pincus Shapiro

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mollye -----

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14
Informant J. Lewis
(Address) 1439 E. Balto. St.

15
Filed JUNE - 1924 192.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pul. TB-

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)
6/6/24 192 (Address) 1423 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Rosedale

DATE OF BURIAL 6/8 192 4

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto st

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

87668 X179 D 87668

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 9 WARD)

2-FULL NAME Marageret H. Bissell

(a) RESIDENCE No. Putty Hill Ave (Fullerton) ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) Nov 6/1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	7	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country)

PARENTS

10 NAME OF FATHER Geo. F. Bissell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Adams Mass.

12 MAIDEN NAME OF MOTHER Miranda Magness

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Geo. F. Bissell
(Address) Fullerton Md

15 Filed JUN 8 1924, 192 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1st, 2nd & 3rd degree burns over almost entire body. Accidental Clothes caught fire from coal cooking stove

(Duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Watts, M. D.
(Coroner.)

6-7, 1924 (Address) 508 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery DATE OF BURIAL June 8 1924

20 UNDERTAKER Fredk Lassahn & Sons ADDRESS Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87669

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1009 N Central Ave 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Emma Schuchard

(a) Residence No. 1009 N Central Ave St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~ Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George Schuchard

6-DATE OF BIRTH (month, day and year) Feb 3 1857

7-AGE, 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant) Helen Hamstead

(Address) 1009 N Central Ave

15- Filed JUN 8 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7/24

17- I HEREBY CERTIFY, That I attended deceased from June 6, 19 24, to June 7, 19 24

that I last saw h.r. alive on June 6, 19 24

and that death occurred, on the date stated above, at 4 55 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arterial sclerosis

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John J. Finch, M. D.

6/7, 1924 (Address) 936 E Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cemet

DATE OF BURIAL, June 8, 19 24

20-UNDERTAKER, Williamson

ADDRESS 502 E Baltimore

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87670

CERTIFICATE OF DEATH.

90 D 87670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2801 (ST.,) Remington av (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Tittle

(a) RESIDENCE NO. 2801 (ST.,) Remington Av (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced (or) WIFE of Thomas Tittle

6 DATE OF BIRTH (month, day, and year) May 17/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	95		24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Thomas Hollins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Shorter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co.

14 Informant Jane Little
(Address) 2801 Remington Ave

15 Filed JUN 8 - 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Krauser, M. D.
(Coroner.)

June 6, 1924 (Address) 502 Poplar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 9 1924
20 UNDERTAKER	ADDRESS
P S Marshall	353 Fall Rd

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Lawrence M. Conway

D 87671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 87671

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2044 S Charles ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. — Lawrence M. Conway

(a) RESIDENCE. No. 2044 S Charles ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If ~~married, widowed~~ or ~~divorced~~ HUSBAND of (or ~~WIFE of~~) Agnes Conway

6 DATE OF BIRTH (month, day, and year) March 24 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry

(c) Name of employer Knox Dept Store Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Simms Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha Rusk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Mary Eyerly (Address) 2044 S Charles St.

15 Filed JUN 8 - 1924 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1924

17

I HEREBY CERTIFY, That I attended deceased from June 4 1924, to June 5th 1924, that I last saw h[illegible] alive on June 5th 1924, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/7, 1924 (Address) 1294 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	June 9 1924

20 UNDERTAKER Margaret L. Hyson

ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87672 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87672

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 404 E. 22nd St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rebecca C. Rose

(a) Residence No. 404 E. 22nd St., 12 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Thurman Rose

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer). Odd

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Delaware, U.S.A.

PARENTS.

10-NAME OF FATHER. Harry Walter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). U.S.A.

12-MAIDEN NAME OF MOTHER. not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). not known

14- (Informant) David C. Rose

(Address) Newark, Delaware

15- JUN 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 8, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 7th 19 24 to June 8 19 24

that I last saw her alive on June 8th 19 24

and that death occurred, on the date stated above, at 11 55 A.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) several yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

6/8/ 1924 (Address) 3014 St Paul St

*State the **Disease Causing Death**, or In deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Townsend Del.	6/9/24 19
20-UNDERTAKER. J. Walter Jenkins	ADDRESS 623 E. North Ave.

Spec.–1-10-21 M&T 1500 Bks.

172477 D 87673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 60-001 D 87673

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter R Myers

(a) RESIDENCE No. Mtg H. Va. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer W. Va

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Elmer Myers

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Hershelman

13 BIRTHPLACE OF MOTHER (city or town) W. Va.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to June 7, 1924, that I last saw h... alive on June 7, 1924, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial failure
from Exophthalmic
goiter

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Thyroid intoxication

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/5/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

(Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mtg K. Va — DATE OF BURIAL June 8 1924

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 E Way

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87674

101-001

D 87674

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Lee

(a) RESIDENCE. No. 1429 Myrtle St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 JUN 9 - 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 4 1924

17 I HEREBY CERTIFY, That I attended deceased from 5 - 12, 1924, to 6 - 4, 1924

that I last saw him alive on 6 - 4, 1924

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Emphysema (Post-Pneumonic)

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Bruce, M. D.

6-4 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL

20 UNDERTAKER ADDRESS

JUN 7 1924

Commissioner of Health

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87675

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D 87675

REGISTERED NO.

CITY OF BALTIMORE: (No. Woman's Hosp. John ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Berry De Murguondo

(a) RESIDENCE NO. 1518 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or cuuntry) Baltimore Md.

PARENTS

10 NAME OF FATHER Howard de Murguondo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Berkeley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant
(Address)

15 JUN 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17

I HEREBY CERTIFY, That I attended deceased from 3.30 P.M. June 6, 1924 ar, to 5.30 P.M. June 6, 1924.

that I last saw h[illegible] alive on June 6, 1924.

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth. -
Cause undetermined.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical exam.

(Signed) J. Cyle Worfield Jr., M. D.

, 19 (Address) Woman's Hospital City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUN 7 - 1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Maker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87676

CERTIFICATE OF DEATH.

31 D 87676

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 W. Hennelle ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Mackey (or Markert)

(a) RESIDENCE NO. 212 - Hennelle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Mackey

6 DATE OF BIRTH (month, day, and year) June 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Spiggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Eliza (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Benj Taylor (Address) 212 - Hennelle

15 Filed JUN 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to June 5, 1924.

that I last saw her alive on June 5, 1924.

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

MD

(History MD 2 months)

(duration) 1 yrs. 6 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) Walter J. Toadvine, M. D.

, 19 (Address) 212 W. Hennelle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL June 9 1924

20 UNDERTAKER John W. Toadvine

ADDRESS 212 W. Hennelle St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87677

CERTIFICATE OF DEATH.

D 87677

1-PLACE OF DEATH Age men & women's home

REGISTERED NO. 74

CITY OF BALTIMORE: (No. 1622 Druid Hill Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Bond

(a) RESIDENCE NO. 1622 Druid Hill Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate in home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Josiah Wilmer

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Martha —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Emma Jones
(Address) 1622 Druid Hill Ave

15 Filed JUN 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1924, to June 7, 1924

that I last saw her alive on June 7, 1924

and that death occurred, on the date stated above, at 10 p' m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Wheeler, M. D.

6/8/1924 (Address) 1736 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 9 1924
20 UNDERTAKER John H. Trader	ADDRESS 142 Ostend St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Mass James

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

D 87678

CERTIFICATE OF DEATH.

D 87678

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Age near former 21st St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs James

(a) RESIDENCE NO. 1622 Division St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate in home

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Emma Jones

(Address) 1622 Division Ave

15 JUN 9 - 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1924, to June 7, 1924, that I last saw him alive on June 7, 1924, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 6 mos 8 ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Mullen M. D.

6/8/1924 (Address) 1230 Division St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 9 1924
20 UNDERTAKER John H. Frederick	ADDRESS 142 Ostend St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87679

CERTIFICATE OF DEATH.

74-001

74 D 87679

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1710 W Pratt ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William G Cresswell

(a) RESIDENCE. No. 1710 W Pratt ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: WK

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Laura D. Cresswell

6 DATE OF BIRTH (month, day, and year): Dec 26 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Francis Cresswell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louisa G Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. W. B. Cresswell (Address) 1710 W Pratt St

15 Filed JUN 9 - 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 3rd, 1924, to June 6th, 1924, that I last saw h.. alive on June 6th, 1924, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Capapleksy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Amos Pinkard M. D.

6/9, 1924 (Address) 26 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 9 1924
20 UNDERTAKER: Joseph B. Cook	ADDRESS: 1003 W Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37680 — 37680

REGISTERED NO. 24 109 37680

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 W. Lanvale ST.) 16 WARD)

2-FULL NAME May A. Peddicord

(a) RESIDENCE. NO. 1405 W. Lanvale ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married —

3a If married, widowed or divorced — HUSBAND of (or) WIFE of Frank A Peddicord

6 DATE OF BIRTH (month, day, and year) Oct 20 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work when active

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country) Howard Co Md.

PARENTS

10 NAME OF FATHER Geo F. Lenzie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant (Address) Frank A Peddicord 1405 W Lanvale St.

15 Filed JUN 9 - 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7- 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec 4- 1923, to Jan 7 - 1924, that I last saw her alive on Jan 4 - 1924, and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy. (2nd attack)

— about one half hour —
(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Arteriosclerosis
Probably several years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) Carlton M. Peck M. D.

June 7, 1924 (Address) 2219 St. Paul Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Grove Cemy	June 9 1924
20 UNDERTAKER Carl M. Hartz	ADDRESS Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87681

D 87681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Aged Mens Home St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Wilkens

(a) Residence No. 1400 W. Lexington St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Wid

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 6/1/1842

7-AGE. 82 yrs. — mos. 6 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Wilkens

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Core

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) Mrs Blanch Fowler

(Address) Matron 1400 W Lexington St

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

JUN 9 - 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from June, 19 24, to June 7, 19 24, that I last saw h...alive on June 7, 19 24, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) ....yrs....mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

June 9th, 19 (Address) 937 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	June 9, 1924
20-UNDERTAKER.	ADDRESS
George J. Smith	1632 Hollins St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87682

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ D 87682

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Briscoe ST., 21 WARD)

2-FULL NAME Thomas Jones

(a) RESIDENCE NO. 1109 Briscoe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jones.

6 DATE OF BIRTH (month, day, and year) ~ - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Jones
(Address) 1109 Briscoe St

15 Filed JUN 9 - 1924 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/ 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/22/ 1924, to 6/5/ 1924
that I last saw h... alive on 6/5/ 1924
and that death occurred, on the date stated above, at 3.00 A. m.

The CAUSE OF DEATH* was as follows:

Acute Uremia
(Primary etc.)
(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Nephritis Parenchymatous
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical microsc

(Signed) J. Guy Bowley M. D.

6/8/ 1924 (Address) 908 Stiles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auburn cemetery — DATE OF BURIAL: June 9 1924

20 UNDERTAKER Edward Bryan — ADDRESS 1691 orleans st

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87683

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1410 N.Fulton Ave. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Martha Schwartz,

(a) Residence No. 1410 N.Fulton Ave. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.)
Female	White	Married

5a-If married, ~~widowed, or divorced~~ ~~HUSBAND of (or)~~ WIFE of Edward M.Schwartz,

6-DATE OF BIRTH (month, day and year) July 7,1898

7-AGE,	If LESS than 1 day,
25 yrs. 11 mos. -- ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Frank A.Mielke,

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Kenna,

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant) Edward M.Schwartz,
(Address) 1410 N.Fulton Ave

15- JUN 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) JUN 7 - 1924

17- I HEREBY CERTIFY, That I attended deceased from May 30, 19 24, to June 6 19 24
that I last saw h er alive on June 6 19 24
and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

Both lungs.

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal T.B.

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Edward Murray M. D.
JUN 7 1924, 19 (Address) 1321 W. Lafayette Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION~~ OR ~~REMOVAL~~,	DATE OF BURIAL,
Holy Cross A.C.Co	JUN 10 1924 19..

20-UNDERTAKER,	ADDRESS
Geo W Little	2700 EDMONDSON AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87684

CERTIFICATE OF DEATH.

D 87684

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 Marshall St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Rosa Ella Fekays

(a) Residence No. 1603 Marshall St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 1 1923

7-AGE, 1 yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John J. Fekays

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Mary E Schwenk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) John J. Fekays

(Address) 1603 Marshall st

JUN 9 - 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6 - 1924

17- I HEREBY CERTIFY, That I attended deceased from June 2 19 24 to June 6 19 24

that I last saw h. alive on June 6 19 24

and that death occurred, on the date stated above, at 10 20 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) J. W. Downes M. D.

June 9 1924 (Address) 1218 Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cemetery — DATE OF BURIAL, June 9, 1924

20-UNDERTAKER. Robt H Turner Jr — ADDRESS 1442 N Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87685

CERTIFICATE OF DEATH.

D 87685

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 876 w Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Marion J Merson

(a) Residence No.... 876 w Fayette St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feby 12 - 1922.

7-AGE, 2 yrs. 3 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Harry Merson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Eva Allen

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va.

14- (Informant) Mr Harry Merson

(Address) 876 W Fayette St

15- JUN 9 - 1924 ROBERT R. KRAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 8th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 5, 19.24, to June 8, 19.24, that I last saw h.. alive on... June 8, 19.24, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) — yrs. 1½ mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Thos Yonton, M. D.

6/9/24 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, June, 19 24
Loudon Park Cem	
20-UNDERTAKER Colby Boyce & Sons	ADDRESS 901 Hollins St
Jeff G. Howard	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87686

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

188-003

18 D 87686

Registered No. C.....

City of BALTIMORE: (No. Municipal Hospital St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Sentz

(Residence in Baltimore: No. 3713 Roland ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: Unknown, ... 1..... (Month) (Day) (Year)

7-AGE: 39 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steam
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Jermiah Sentz

11-BIRTHPLACE OF FATHER, (State or Country): md

12-MAIDEN NAME OF MOTHER: Laura Sentz

13-BIRTHPLACE OF MOTHER, (State or Country): md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bell Sentz

(Address) 3238 St Charles Ave

15- JUN 9 - 1924 ROBERT R. KRAUTER, Registrar.

(Date) 192.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1924. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Communicated

Comp. Comminuted fracture Skull Laceration of Brain Injuries Automobile accident (Duration) ..yrs. ..mos. 6 ds.

CONTRIBUTORY (Secondary) .....(Duration) ..yrs. ..mos. ..ds.

(Signed) James M Fenton M. D. (Coroner)

June 9, 1924 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place of death ..yrs. ..mos. 6 ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted if not at place of death? Essex Balto Co

Former or usual residence 1713 Roland ave

19-PLACE OF BURIAL OR REMOVAL: Woodlawn

DATE OF BURIAL: June 10 1924

20-UNDERTAKER: Ehrenwerth & Son

ADDRESS 3617 Chestnut ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

(See affadavit and letter sent from James Claypoole and returned. June 10th 1924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87687

CERTIFICATE OF DEATH.

31

D 87687 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Koehler

(a) Residence No. 147 N. High st. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Unknown

6-DATE OF BIRTH (month, day and year): ~~1866~~ Jan 26 1865

7-AGE: ~~58~~ 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS.

10-NAME OF FATHER: Geo. Koehler

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Elizabeth Price Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant): Hospital Records

(Address): M. T. H.

JUN 9 - 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 6, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 8 1924 to June 6 1924

that I last saw him alive on June 6 1924

and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray and sputum

(Signed) L. A. Lally M. D

6-6-24. 19 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St. Matthew

DATE OF BURIAL: June 9 1924

20-UNDERTAKER: William Eshaffer

ADDRESS: 816 Monument st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D 87688 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D 87688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 2914 E Pratt St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Wemboldt

(a) Residence No. 2914 E Pratt St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

~~5-Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa F. Kimball

6-DATE OF BIRTH (month, day and year) Dec 15 1878

7-AGE. 78 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Lieut. 032
(b) General nature of industry, business, or establishment in which employed (or employer)..... Fire Dept
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country),

PARENTS.

10-NAME OF FATHER Albert Wemboldt

11-BIRTHPLACE OF FATHER (city or town)..... Balto
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Wiggaman

13-BIRTHPLACE OF MOTHER (city or town)..... Balto
(State or Country), Balto Md

11- (Informant) Mrs Rosa F. Wemboldt
(Address) 2917 E Pratt St

15- Filed JUN 9 - 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 7 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1924 to June 7 1924

that I last saw him alive on June 7 1924

and that death occurred, on the date stated above, at 9.20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Septic Absorption

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah F. Russell, M. D.

, 19 (Address) 526 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount Carmel — DATE OF BURIAL, June 11, 1924

20-UNDERTAKER, John Ulrich — ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87689

CERTIFICATE OF DEATH.

12 9 D 87689

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 606 E. Biddle St., 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME..... Michael Connor

(a) Residence No. 606 E. Biddle St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Margaret A. Connor

6-DATE OF BIRTH (month, day and year): Oct 11-

7-AGE: 73 yrs. 7 mos. 28 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engineer 30
(b) General nature of industry, business, or establishment in which employed (or employer): Stationary
(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.
10-NAME OF FATHER: John Connor
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12-MAIDEN NAME OF MOTHER: Elizabeth Dunn
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Margaret M. Connor
(Address) 606 E. Biddle St.

15- JUN 9 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 7 1924

17- I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to June 7, 1924, that I last saw h[illegible] alive on June 7, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:
Chr. Nephritis - Chr. Myocarditis.
Double Broncho-pneumonia
..... (Duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of.....
Was there an autopsy? No
What test confirmed diagnosis? Usual Symptoms
(Signed) J. F. Kirby, M. D.
June 8, 1924 (Address) 1106 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: June 10, 1924

20-UNDERTAKER: H. C. Wiedefeld — ADDRESS: 914 Greenmount Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87690

CERTIFICATE OF DEATH.

74-001 D 87690

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326-N-Mount ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Reed

(a) RESIDENCE NO. 326-N-Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Reed

6 DATE OF BIRTH (month, day, and year) March 2-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va.

PARENTS

10 NAME OF FATHER Edmund Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co Va

12 MAIDEN NAME OF MOTHER Martha Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co Va

14 Informant John W. Bunyon

(Address) 621 Pine St

15 Filed JUN 9 1924 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 6, 1924,

that I last saw h alive on June, 1924,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms — Physical Signs

(Signed) C. Walter Hartung, M. D.

, 19 (Address) 618 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 9 1924
20 UNDERTAKER Brown & Leyland	ADDRESS 114 W. Lexington St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87691

CERTIFICATE OF DEATH.

22 D 87691

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 Archer ST., 21 WARD)

2-FULL NAME Mary Agnes Wilson

(a) RESIDENCE NO. 515 Archer ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Harry E Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes A Reinhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harry E Wilson

(Address) 515 Archer St

15 JUN 9 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to June 8, 1924, that I last saw her alive on June 7, 1924, and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Anterior Poliomyelitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) C L Buxton, M. D.

6/9/24 (Address) 301 East Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 10 1924
20 UNDERTAKER	ADDRESS
John J Fields	1200 W Lombard

Cor.—1-12-23—M&T—100 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87692

CERTIFICATE OF DEATH.

100 .001 ✓

D 87692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~1317 Jefferson~~ Johns Hopkins Hospital ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Jefferson

(a) RESIDENCE NO ~~1317 Jefferson~~ 1367 Chapel st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXX

6 DATE OF BIRTH (month, day, and year) Aug 31/23

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work XXXXX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Jefferson

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Emma Taylor

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14
Informant Emma Jefferson
(Address) 131[illegible] Jefferson

15
Filed JUN 9 - 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/24 [19]92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Richits (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Bullen, M. D.
(Coroner.)

June 9/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 9 192 4

20 UNDERTAKER Mac R. C. Elliott — ADDRESS [illegible]

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

172071 Wd 87693

CERTIFICATE OF DEATH.

X 135D 87693

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME William Cuttings

(a) RESIDENCE NO. 3 Linden Ave Overlea Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ ?

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) Odo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Lindenwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Reeds (Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUN 9 - 1924 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to June 6 - 1924.

that I last saw him alive on June 6, 1924

and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Uremia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles G. Bidgood, M. D.

, 19 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
J. J. Peters Cemetery	June 10 19 24
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	1726 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87694

179 D 87694

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST., 21 WARD)

2-FULL NAME Josephine E. Jeffries

(a) RESIDENCE NO 1182 N. Smallcake st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 8, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Jeffries

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Mae C. King

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant ..... Samuel Jeffries.
(Address) 1182 N. Smallcake St

15 JUN 9 - 1924 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or~~ inquiry I thereon and from the evidence obtained by said ~~inquest, au-~~ ..... find that said deceased came to ~~topsy or~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns on body + shock

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Accidentally ingested pot pot of Boiling water (duration) ..... yrs. ..... mos. ..... ds.

(Signed) T K Gorman, M. D.
(Coroner.)

6-7-, 1924 (Address) 117 W. Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 9 1924
20 UNDERTAKER	ADDRESS
Fred A. Kramer & Son.	703 Hanover st

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stoc—12-23-21—E.B.R.S.—400 Blks.

D 87695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87695

1-PLACE OF DEATH

City of BALTIMORE: (No. 1515 N. Gilmor St., 15 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... David Honeyman

(a) Residence No... 1515 N Gilmor St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) widowed

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Delia Boyle

6-DATE OF BIRTH (month, day and year) Apr 20 th 1850

7-AGE, 74 yrs. 1 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Shoe maker

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 57 yrs

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Scotland

14- (Informant) Mrs Mary E Honeyman

(Address) 1515 N Gilmor St

15- JUN 9 - 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7-1924

17- I HEREBY CERTIFY, That I attended deceased from 5/30/24, 19..., to 6/7/24, 19..., that I last saw him alive on 6/7/24, 19..., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Ch. Bronchitis

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ... 2 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. H. Mason, M. D.

6/8/24, 19 (Address) 1302 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine Park Cem. | DATE OF BURIAL, June 10, 1924

20-UNDERTAKER, Peter J. Gowan & Son | ADDRESS, 701 W. Lexington St

Per W. J. Gowan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87696

CERTIFICATE OF DEATH.

90 D 87696

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 Polk St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Seibach

(a) Residence No. 13 Polk St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND ~~of (or)~~ WIFE of Mary A. Seibach

6-DATE OF BIRTH (month, day and year) Nov. 2 1862

7-AGE. 61 yrs. 7 mos. 5 ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clothing 080

(b) General nature of industry, business, or establishment in which employed (or employer). Cutter

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Charles Seibach

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Not Known

14-

(Informant). Mrs. Mary A. Seibach

(Address). 13 Polk St.

JUN 9 - 1924

ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1922 to June 7 1924

that I last saw him alive on June 7 1924

and that death occurred, on the date stated above, at 5-20 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

6/8/24 19 (Signed) Fritz J. Kinzey M. D

(Address) 2700 Hilford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. June 10 1924

20-UNDERTAKER. Henry Hoeck Son

ADDRESS 1301 E Eager St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87697

CERTIFICATE OF DEATH.

90 D 87697

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1443 Montpelier St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Agnes Burgan

(a) Residence No. 1443 Montpelier St., Ward

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widow(er), or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jo Cole John J. Burgan

6-DATE OF BIRTH (month, day and year): Not Known

7-AGE: about 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS

10-NAME OF FATHER: Daniel Kenney

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Anna Leahey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant): Mrs Anna J. Bamberger

(Address): 1443 Montpelier St.

JUN 9 - 1924

ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 8 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to June 8, 1924

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

old age

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Heart disease Valvular disease

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Young Wuthrak M. D

June 9, 1924 (Address) 1600 Fredrick ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	June 11, 1924
20-UNDERTAKER.	ADDRESS
Henry Hoeck Son	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S—400 Bks.

D 87698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87698

CERTIFICATE OF DEATH.

X 118-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Rosario

(a) Residence No. Prospect Park - Back River St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary E Dorsey

6-DATE OF BIRTH (month, day and year) Aug. 1849

7-AGE. 74 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Spain

PARENTS.

10-NAME OF FATHER, Pedro Rosario

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Spain

12-MAIDEN NAME OF MOTHER, Josepha Rosary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Spain

14- (Informant) Mdme Wm Schuler

(Address) Colgate Md

15- Filed 1924 Robert P. Harrison, 192 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to June 7, 1924

that I last saw him alive on June 7, 1924

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Varicose Ulcer of Leg

Syphilis (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 3, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. F. Mullen, M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Dayhaven	June 11, 1924
20-UNDERTAKER,	ADDRESS
Wm Cook	502 E Monument St

ON9

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87699 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87699

52

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 5616 Gorsuch Ave St. 71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Irene Kolbe

(a) Residence No. 5616 Gorsuch Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura -

6-DATE OF BIRTH (month, day and year) Jan 12 1839

7-AGE.	If LESS than 1 day,
85 yrs. 7 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Painter 063

(b) General nature of industry, business, or establishment in which employed (or employer)..... Painter

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER. Julius Kolbe

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Ida Kolbe

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant) Mrs Ida Kolbe

(Address) 5622 Gorsuch Ave

15- Filed JUN 9 1924 Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 5 1924

17- I HEREBY CERTIFY, That I attended deceased from June 6 1924 to 1924

that I last saw h.. alive on June 8 1924

and that death occurred, on the date stated above, at 6 m

The CAUSE OF DEATH was as follows:

Chronic Rheumatism

Enteritis

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. O Woolley, M. D

19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Baltimore	June 11 1924

20-UNDERTAKER,	ADDRESS
Wm Cook	502 E Fay Ave

Burial Permit Clerk

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 87700

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87700

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 7 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Byrne

(a) RESIDENCE No. 714 N. Luzerne ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Elizabeth Byrne

6 DATE OF BIRTH (month, day, and year) March 19. 1876 1884

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Horseshoer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Mannion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. E. A. Pond
(Address) Brooklyn Md.

15 Filed JUN 9 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7- 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ulcer. Nephritis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. 1 ds.

(Signed) G. C. Bladen, M. D.

6/9/24 192 (Coroner) (Address) 143 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 10 1924
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87701

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87701

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 First ave ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Long

(a) RESIDENCE NO. 3501 First ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Long

6 DATE OF BIRTH (month, day, and year) June 9-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	73	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ~~None~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Conrad Weis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Virginia Long

(Address) 3501 First ave

15 Filed JUN 6 1924, 19 ROBERT F. MARTIN, Registrar

Burial Permit Cl[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1924, to June 6th, 1924, that I last saw her alive on June 5th, 1924, and that death occurred, on the date stated above, at 9.10 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) about yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D W Jones M. D.

6-7-1924 (Address) 1011 Hollewood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	June 10 1924
20 UNDERTAKER	ADDRESS
Zirkin + Zirkin	1739 E Eager

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87702

CERTIFICATE OF DEATH.

D 87702

38 REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 141 N. Linwood ave ST., 6th WARD)

2-FULL NAME Dolores May Butta

(a) RESIDENCE No. 141 N. Linwood ave ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. 4 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30th 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... old

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Butta

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Margaret Chiego

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant John Butta
(Address)

15 Filed JUN 9 - 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1924, to June 8, 1924.

that I last saw h alive on June 7, 1924

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Abscess of Liver

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Specific old

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Wm L. Valentine, M. D.

June 9, 1924 (Address) 1 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 10th 1924

20 UNDERTAKER Frank V. Lipsitone — ADDRESS 1810 E. 32nd St

Spec.—1-10-21—M&T—1500 Bks.

D 87703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87703

CERTIFICATE OF DEATH.

+46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marietta St. Chisum

(a) RESIDENCE No. Gloucester, Va. St., WARD

(Usual place of abode) (If non-resident give city or town and State) Virginia

Length of residence in city or town where death occurred — yrs. — mos. 10 ds. How long in U. S., If of foreign birth? 42 yrs. 0 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry L. Chisum

6 DATE OF BIRTH (month, day, and year) May 17, 1882

7 AGE Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
42	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home-maker

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Isaac Shughuff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County Maryland

12 MAIDEN NAME OF MOTHER Susan Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Harry L. Chisum (Address) Gloucester Virginia

15 Robert F. Harrison, Registrar

JUN 9 - 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 8, 1924, that I last saw h[illegible] alive on June 8, 1924 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

— (duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Tachycardia

(duration) ....yrs. ....mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 4, 1924

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) Thomas [illegible] M. D.

, 19 (Address) 225 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ware Church - Gloucester Co. Va.

DATE OF BURIAL June 9th 1924

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D 87704

HEALTH DEPARTMENT—CITY OF BALTIMORE

16 ✓ D 87704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Starr

(a) RESIDENCE NO. 417 E. Joppa Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 9, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or 5 min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ nil

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md. Gen'l. Hospital Baltimore, Md.

PARENTS

10 NAME OF FATHER Ambrose G. Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓ N.C.

12 MAIDEN NAME OF MOTHER Helen C. Carmichael

13 BIRTHPLACE OF MOTHER (city or town) No. Carolina (State or country) Pennsylvania Co.

14 Informant Ambrose G. Starr
(Address) 417 E. Joppa Rd Towson Md

15 Filed JUN 9 1924, 19.. Robert F. Harrison.
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to same, 19..,
that I last saw her alive on June 9, 1924,
and that death occurred, on the date stated above, at 11 20 A m.
The CAUSE OF DEATH* was as follows:
Congenital Telectasis

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) ..... no Asapkins ....., M. D.

, 19 (Address) Mt Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 10 1924
UNDERTAKER	ADDRESS
John O. Mitchell	2018 Fayette

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87705

43 D 87705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Key Ave., Mt. Washington, 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas F. Pflieger,

(a) RESIDENCE No. Key Ave., Mt. Washington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Pflieger

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penn. R. R.

9 BIRTHPLACE (city or town) York
(State or country) Pa.

PARENTS

10 NAME OF FATHER Edw. Pflieger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Jessie Furman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Mrs. Rose C. Pflieger
(Address) Key Ave., Mt. Washington

15 Filed JUN 9 1924, 192 Robert F. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue and throat

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. F. Harrison (Coroner.) M. D.

1924 (Address) 363 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	June 10 1924
20 UNDERTAKER Wm. J. Tickner & Son	ADDRESS North Penn.

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPA[redacted] OF BALTIMORE

D 87706 D 87706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bayview Hospital 179 Registered No.

City of BALTIMORE: (No. 16 St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elora Brooks

(a) Residence No. 1908 Edmondson Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1875

7-AGE. 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Wayne Co Ind

PARENTS.

10-NAME OF FATHER, John Walton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Catherine Kinnard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Bayview Hospital

(Address)

15- Filed 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9. 1924

I HEREBY CERTIFY, That I attended deceased from June 5 1924 to June 9 1924

that I last saw h. alive on June 8 1924

and that death occurred, on the date stated above, at 8 09 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Acute)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. Hedesmith, M. D.

, 19 (Address) Bayview Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Butler Md DATE OF BURIAL. June 12 1924

20-UNDERTAKER. Wm J Pickner Sons ADDRESS North & Pa

JUN 9 - 1924

INSTRUCTIONS—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Poehler

D 87707

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87707

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 Barclay St. ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Lee Poehler

(a) RESIDENCE NO. 2527 Barclay St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry W Poehler

6 DATE OF BIRTH (month, day, and year): May 23-1899

7 AGE: Years 25 | Months — | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Salisbury Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Harry W. Poehler 2527 Barclay St

15 Filed JUNE 9 1924, 19

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1924

17

I HEREBY CERTIFY, That I attended deceased from Sept 11 1923, to June 8 1924,

that I last saw her alive on June 8 1924,

and that death occurred, on the date stated above, at 12.59 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo W Thompson M.D.

6/9/1924 (Address) 401 E 25th St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: June 11 1924

20 UNDERTAKER: Wm J Tickner & Sons

ADDRESS: North Ave

Spec.—1-10-21—M&T—1500 Bks.

D 87708

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87708

CERTIFICATE OF DEATH.

REGISTERED NO. 122

1-PLACE OF DEATH Colonial Hosp

CITY OF BALTIMORE: (No. 1112 N. Mount ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Koziel

(a) RESIDENCE NO. 1227 7th, Rear ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) widower

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Magdalena Koziel

6 DATE OF BIRTH (month, day, and year) June 29, 1872

7 AGE Years 52 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet-maker

(b) General nature of industry, business, or establishment in which employed (or employer) Piano Mfg. 014

(c) Name of employer Knabe Bros.

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Frank Koziel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Marie Glaczki

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Dr. Hennig (Address) 2000 Hollins St.

15 JUN 9 1924 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1924, to June 7, 1924.

that I last saw him alive on June 7, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver several years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema 3 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 10, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. A. Susong M. D.

, 19 (Address) 1112 North Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cemetery

DATE OF BURIAL June 10 1924

20 UNDERTAKER J. William Offutt, Sr.

ADDRESS 1151 W. Garrison Lane

MARGIN RESERVED FOR BINDING

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 2494 D 87709 — 101-001 D 87709

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lelma Dixon

(a) RESIDENCE NO. Valley Md Box 57.0 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 30/1921

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) +

(c) Name of employer +

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Manuel Dixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Boddie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 JUN 1 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1924 to June 5, 1924.

that I last saw h[illegible] alive on June 5, 1924.

and that death occurred, on the date stated above, at 8 20 A.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Home

What test confirmed diagnosis?

(Signed) Chas R Bruce, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Valley md a.a.co

DATE OF BURIAL 10 June 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 orleans st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87710

CERTIFICATE OF DEATH.

129

D 87710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ina Lavia Wilson

(a) RESIDENCE NO. 1222 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: widower

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49				

8 OCCUPATION OF DECEASED: labor 040

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): King an queen co. Va

PARENTS

10 NAME OF FATHER: John wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Frank wilson

(Address): 1222 Jefferson

15 Filed JUN 10 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1924, to June 8, 1924, that I last saw him alive on June 8, 1924, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis, Arteriosclerosis Hypertension Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1222 Jefferson St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B Lybert, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Point King an Queen co. Va

DATE OF BURIAL: 11 June 1924

20 UNDERTAKER: Edward Bryson

ADDRESS: 681 orleans st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Savoy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87711

CERTIFICATE OF DEATH

101-001

D 87711

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 660 Haw ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Savoy

(a) RESIDENCE. No. 660 Haw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6 1918

7 AGE	6	Years	Months 1	Days 1	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) — Nothing

(c) Name of employer — "

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Savoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Elizabeth Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md

14 Informant William Savoy
(Address)

15 Filed JUN 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to June 7, 1924
that I last saw her alive on June 7, 1924
and that death occurred, on the date stated above, at 8.15 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. N. Hincs, M. D.

June 7 1924 (Address) 712 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	6-10-1924
20 UNDERTAKER David Easton	ADDRESS 916 Penna

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spesc.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87712

CERTIFICATE OF DEATH.

D 87712

1-PLACE OF DEATH

REGISTERED NO. 15-90

CITY OF BALTIMORE: (No. Municipal Hospital St.: 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tiffoney Mitchell

(a) RESIDENCE. No. 1310 Vincent St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Municipal Hospital Penna

15 JUN 1 0 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 8 1924

17 I HEREBY CERTIFY, That I attended deceased from 6 - 7, 1924 to 6 - 8, 1924

that I last saw him alive on 6 - 8, 1924

and that death occurred, on the date stated above, at 8 40 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic myocarditis

Myocardial insufficiency

(duration) 1 yrs. (Chronic) mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & autopsy

(Signed) Claude S. Dean M. D.

6 - 9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-11-24
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Penna

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

11255 D 87713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-002 D 87713

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brauer

(a) RESIDENCE No. 802 Powers ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Cute mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 8-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Bleasing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed JUN 10 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 9, 1924.

that I last saw her alive on June 9, 1924,

and that death occurred, on the date stated above, at 7 A. M. m.

The CAUSE OF DEATH* was as follows:

Brain Injury (Meningeal Hemorrhage)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Dunn M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	June 10 24

20 UNDERTAKER Chenoweth Son ADDRESS 617 Chestnut

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87714

100-001 D 87714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 865 Pierce ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Phillips

(a) RESIDENCE NO. 865 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE — Years: 47 — Months: ? — Days: ? — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic at

(b) General nature of Industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N C

PARENTS

10 NAME OF FATHER: Peter Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Matilda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: George Palmer

(Address) 865 Pierce Ave.

15 Filed JUN 1 0 1924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-7 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924, to June 7, 1924, that I last saw her alive on June 7, 1924, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McRae, M. D.

6-9, 1924 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL 1924

20 UNDERTAKER: Samuel Kinsley

ADDRESS 857 W. Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

(See Letter on file from I. I. Levy MD Sept 18-1924)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87715

CERTIFICATE OF DEATH.

D 87715

74

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 3 WARD)

2-FULL NAME Mrs. Ida Lubell (or Sobel)

(a) RESIDENCE No. 1157 E. Lombard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 30 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	~~widowed~~ married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Lubell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant I. Levy

(Address) 1439 E. Balto. St.

JUN 1 01924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to June 4, 1924.

that I last saw h... alive on June 8, 1924,

and that death occurred, on the date stated above, at 2:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage,
Arteriosclerosis

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidore I. Levy, M. D.

June, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int. Cem. Rd — DATE OF BURIAL 6/10 1924

20 UNDERTAKER Joseph Lewis — ADDRESS 1439 E. Balto St.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87716

CERTIFICATE OF DEATH.

46

D 87716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Isaacson

(a) RESIDENCE NO. 1405 E. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Benj Isaacson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dosoh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1439 E Baltst

15 Filed JUN 1 0 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1924

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1924, to June 7, 1924, that I last saw her alive on June 7, 1924, and that death occurred, on the date stated above, at 1:10 a m.

The CAUSE OF DEATH* was as follows:

Sympho sarcoma of left ovary with metastases

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 1924

Was there an autopsy?

What test confirmed diagnosis? Laparotomy findings

(Signed) A Hellerstein M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 6/10 1924

20 UNDERTAKER: Jack Lewis 1439 — ADDRESS: E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87717

CERTIFICATE OF DEATH.

47 D 87717

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1621 N. Appleton St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Goldie Taylor

(a) Residence No. 1621 N. Appleton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Taylor

6-DATE OF BIRTH (month, day and year) Feb. 19-1885

7-AGE.	If LESS than 1 day,
39 yrs. 3 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto., Md

PARENTS.

10-NAME OF FATHER, Soloman Kahn

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Kina Oestricher

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

11- (Informant)..... J. Taylor

(Address)..... 1621 N. Appleton

12- JUN 1 01924

13- ROBERT R. KRAUTH, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-9-24

17- I HEREBY CERTIFY, That I attended deceased from Nov 17 19 24 to June 9 19 24

that I last saw h.. alive on June 9 19 24

and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

1 Insanna

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) General Carcinoma

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Harold Kahn M. D.

6/9 19 24 (Address) 3027 W Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Hebrew Friendship	June 11, 1924

20-UNDERTAKER. ADDRESS

Jack Lewis, 1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87718

100-001 D 87718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., V WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 815 S. Ann ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 62

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital (Address)

Filed JUN 1 0 1924

ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-5, 1923, to 6-9, 1924

that I last saw h.. alive on 6-8, 1924

and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

Thrombophlebitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym

(Signed) Claude A Dorsey M. D.

6-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	June 11 1924
20 UNDERTAKER	ADDRESS
Lilly & Zile	403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Blks.

Time of burial extended to Thurs. day a.m. 9 A.M.

D 87719

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87719

J. Frederick Stempel Asst. Com

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 E. Eager ST., 1 WARD)

2-FULL NAME Charles A.C. Chester,

(a) RESIDENCE NO. 1514 E. Eager ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced —
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile 666

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER William H. Chester

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Maynd. Townsend 6.10.24

13 BIRTHPLACE OF MOTHER (city or town) Balto Eagen
(State or country) Md

14 Informant Mrs. H. Chester
(Address) 1514 E Eager st

15 JUN 1 01924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6. 10 19 24

17 I HEREBY CERTIFY, That I attended deceased from 5. 25. 24, 19...., to 6. 10. 24, 19....; that I last saw h in alive on 6. 9. 24, 19....; and that death occurred, on the date stated above, at 9 o-cl a.m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Scarlet Fever

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip B. Taylor, M. D.

(Address) 143 N. William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 12 1924
20 UNDERTAKER	ADDRESS
Henry Stovall Son	1201 E Eager st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87720

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Woodrow Zirkham.

(a) RESIDENCE NO. 923 N. Central ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 13 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Harford Co.

(c) Name of employer Md.

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER John W. Zirkham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Mary E Poteet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant (Address) Mr John W. Zirkham Rte 2 Towsontown Md

15 Filed JUN 1 0 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1924, to 6/9, 1924, that I last saw h[illegible] alive on 6/9, 1924, and that death occurred, on the date stated above, at 6 05 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin G. Weber M.D.

6/9 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery Harford Co. Md

DATE OF BURIAL June 11 1924

20 UNDERTAKER Henry Hoech Son

ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—1500 Blks.

D 8772E

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 8772E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Louis Edward Smith

(a) RESIDENCE NO. 2122 W Lexington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 7 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed~~, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucretia M. Smith

6 DATE OF BIRTH (month, day, and year) April 1 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer Warner Electric Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary E. Hartlove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C

14 Informant Lucretia M. Smith

(Address) 2122 W. Lexington St.

15 JUN 1 01924 ROBERT B. KRAUTER, Clerk. Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-4, 1924, to 6-8, 1924, that I last saw him alive on 6-8, 1924, and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

Chr. endocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure, dilatation (duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Leo A Tamposi Chf. M. D.

19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 11 1924
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	478 S. Paca

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87722

CERTIFICATE OF DEATH

3 D 87722

REGISTERED NO. C .....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 3 Homestead Ave St. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Geo P. Foley

(Residence in Baltimore: No. 3 Homestead Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 17, 1881 (Month) (Day) (Year)

7 AGE 42 yrs. 9 mos. 21 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Solicitor
(b) General nature of industry, business, or establishment in which employed (or employer) 01

9 BIRTHPLACE (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo Foley

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary —?

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Foley

(Address) 3 Homestead Ave

15

JUN1 01924

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6 8, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 1923 to 6-1 1924, that I saw h im alive on 6-1 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Ful 3

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Ret. Apoplexy

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) W. E. Mc M. D.

6 10, 1924 (Address) 632 Bdwy

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Greenmount

DATE OF BURIAL 6/11, 1924

20 UNDERTAKER J. Kelly Dowd

ADDRESS 1318 Eight Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 87723

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2137 W. North Avenue St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hays Whitehouse Jr.

(a) Residence No. 2137 W. North Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 23, 1900

7-AGE: 23 yrs. 11 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, George Hayes Whitehouse

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Sadie Eugenia Hughes

13-BIRTHPLACE OF MOTHER (city or town) Howard County (State or Country) Maryland

14- (Informant) George H Whitehouse Sr.
(Address) 406 E. 20th Street

15- JUN 1 01924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 7th, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to June 7, 1924, that I last saw h~~e~~ alive on June 7, 19~~24~~, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary - Laryngeal and Intestinal Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) A. C. Smith, M. D.

6-9, 1924 (Address) 4509 Liberty Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 10, 24
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 W Balto St

Spec—12-23-21—E.B.R.S.—400 Blks.

Carrie Reichert

D 87724

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001 ✓

CERTIFICATE OF DEATH.

D 87724

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Carrie Reichert

(a) Residence No. 2554 Hollins St., Ward 21st

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Reichert

6-DATE OF BIRTH (month, day and year) Jan 22, 1899 25 yrs

7-AGE, 25 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Mr Edes. Norton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Leona Houghman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore

14-INFORMANT Mrs E. Houghman

(Address) 475 St. Stalewood St

15-FILED JUN 1 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-9-24

17- I HEREBY CERTIFY, That I attended deceased from 6-6- 1924 to 6-9 1924

that I last saw her alive on 6-9- 1924

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer.

Peritonitis - Pleurisy.

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) H V Hooper M. D.

19 (Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Cathedral DATE OF BURIAL. Jun 12 24

20-UNDERTAKER, Wm Cook ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87725

CERTIFICATE OF DEATH.

111-001

D 87725

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Hollins ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Isenhardt

(a) RESIDENCE. NO. 1121 Hollins ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 25 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Bon Ton Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Christian Eisenhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo Eisenhardt
(Address) 1254 W Lombard

15 FILED JUN 1 0 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 9, 1924

that I last saw him alive on June 8, 1924,

and that death occurred, on the date stated above, at 10 5 p m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric ulcer

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History & physical signs

(Signed) E. W. Tuppett, M. D.

19 (Address) 132 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 12 19
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

DO NOT WRITE IN THIS SPACE—RESERVED FOR BINDING

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D 87726

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87726

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Crapper

(a) RESIDENCE NO. 2205 E. Eden St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11 1916

7 AGE 8 Years | Months | 29 Days | If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Crapper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Margaret Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 1 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 8, 1924, that I last saw h[illegible] alive on June 8, 1924, and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:
(a) Tuberculoma of Brain

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Acute Miliary Tuberculosis

(duration) yrs. mos. 13 (?) ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas R Burge M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burs cemetery | DATE OF BURIAL June 12 1924

20 UNDERTAKER Edward Bryan | ADDRESS 1631 Orleans St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.- 400 Blks.

(Gossmann)

D 87727

D 87727

94-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 723 N. Duncan St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maria Elizabeth Gossmann

(a) Residence No. 723 N. Duncan St., 7 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Johann B. Gossmann

6-DATE OF BIRTH (month, day and year) Feb 21st 1845

7-AGE. 79 yrs. 3 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Germany
(State or Country),

PARENTS.

10-NAME OF FATHER, Dont Know

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14-

(Informant).. Mary Oppitz

(Address) 723 N. Duncan St.

15-

Filed JUN 10 1924, 192.....

Robert P. Harrison,
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 8th/24

I HEREBY CERTIFY, That I attended deceased from June 1 1924 to June 8 24

that I last saw h.. alive on June 8 19 24

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

6/10/24 (Signed) William J. Ryan M. D

(Address) 801 S. Ann Eastwood

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer Cemetery	June 11th 1924
20-UNDERTAKER,	**ADDRESS**
Lilly & Zeiler	403 S. Mo[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Eks.

D 87728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87728

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 415 N. Eutaw St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. O'Neal

(a) Residence No. 415 N. Eutaw St., 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margareta O'Neil

6-DATE OF BIRTH (month, day and year) Feb 10th 1856

7-AGE, 68 yrs. 4 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Plumber

(b) General nature of industry, business, or establishment in which employed (or employer). 059

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John O'Neal

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Annie McGinnis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant). Margareta O'Neal

(Address). 415 N. Eutaw St.

15- Filed ..... 192.....

Robert F. Harrison, Registrar.

Burial Permit Clerk

JUN 1 01924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 9th 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15 1924 to June 9 1924, that I last saw him alive on June 9 1924, and that death occurred, on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension, nephritis, arteriosclerosis (Duration) 5 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) L. C. Sobieski M. D.

, 19 (Address) 447 N. Kenwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Patricks Cemetery	June 12 1924
20-UNDERTAKER.	ADDRESS
Lilly & Zeller	4038 Wash Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entry in item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

D 87729

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87729

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore Md ST., ... WARD)

2-FULL NAME Mrs M. Hofnagle (Martha)

(a) RESIDENCE NO. Millers Post Office ST., Md WARD Carroll Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Reinhardt Hofnagle

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carrol County Md.

PARENTS
10 NAME OF FATHER George Frank
11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll County Md.
12 MAIDEN NAME OF MOTHER Ely. Houck.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) [redacted] Carroll Co.

14 Informant Charles Hofnagle
(Address) 317 E. Fort Ave.

15 Robert F. Harrison, Registrar
Burial Permit Clerk.

UN 1 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 10, 1924, that I last saw h.. alive on June 10, 1924, and that death occurred, on the date stated above, at 1 22 a m.

The CAUSE OF DEATH* was as follows:

Pelvenia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cholecystitis + Cholelithiasis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? yes Date of June 8-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab

(Signed) Jno A Englar M. D.

, 19 (Address) Millers Md Rt 1,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millers platoon Carroll Co. Md — DATE OF BURIAL June 11, 1924

20 UNDERTAKER Margaret L. Flynn — ADDRESS 14 W Lafayette Ave

ec—12-23-21—E.B.R.S.—400 Bks.

D 87730

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 133 S. Linwood ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice A. Wolf

(a) Residence No. 133 S. Linwood ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Jno. B. Wolf

6-DATE OF BIRTH (month, day and year) Apr. 25th 1859

7-AGE. 65 yrs. 1 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Home
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. James A Mullen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Bridget Burt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Blanche Wolf
(Address) 133 S. Linwood ave

15- Filed ..... 1924 Robert P. J. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 9th 1924

17- I HEREBY CERTIFY, That I attended deceased from June 6 1924 to June 9 1924 that I last saw her alive on June 8 1924 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis unknown

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. J. McAvoy, M. D.

June 10 1924 Address 839 S. Elkwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem	June 11th 1924
20-UNDERTAKER	ADDRESS
J. A. Moran	3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN1 01924

Cor.—1-12-23—M&T—100 Blks.

D 87731

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Ehrlich

(a) RESIDENCE NO 2200 Henneman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto Ehrlich

6 DATE OF BIRTH (month, day, and year) Unknown 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Michael Schiefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susanne Schick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Clara Hammel
(Address) 2200 Henneman Ave

15 Filed ....., 192.... Registrar

JUN 1 01924

Robert P. Harrison,
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia (Probably Streptoccus)

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Abcess on face (duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Haller, M. D.
(Coroner.)

June 10/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL June 11 1924

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

GE should be stated EXACTLY. PHYSICIANS should state
at it may be properly classified. Exact statement of OCCUPA
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificate.

MARGIN RESERVED

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87732

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-D 87732

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 606 N. Fremont ave ST., 21 WARD)

2-FULL NAME Frank L. Hamilton

(a) RESIDENCE No 606 N Fremont ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Don't Know

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs (Address)

15 Filed ....., 192 Registrar

JUN 10 1924

Robert F. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gerwig, M. D.
Coroner.

6-10, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. A. Co. DATE OF BURIAL 6-11 1924

20 UNDERTAKER Jas Lynam & Son ADDRESS 1004 S. Paca St

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87733

CERTIFICATE OF DEATH.

57

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 19 Belman av Overlea 16th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... P. John Crawley

(a) Residence No. 19 Belman av (Overlea) St. ..... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 1877

7-AGE	If LESS than 1 day
48 yrs. — mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Fire Department

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Peter Crawley

11-BIRTHPLACE OF FATHER (city or town)..... Ireland
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Hughes

13-BIRTHPLACE OF MOTHER (city or town)..... Balto.
(State or Country), Md

14-

(Informant) Mrs. Wm. F. Welsh

(Address) 19 Belman av (Overlea)

15-

Filed ..... 19?

Robert P. Harrison,
Registrar.

JUN 1 01924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 7 1924 to June 9 1924

that I last saw him alive on June 9 1924

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Acute Dilatation of Heart (Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetis Mellitus

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted If not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Albert G Webster M. D.

, 19 (Address) 70 E Belan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	, 19....
20-UNDERTAKER, James Dignan & Son	ADDRESS 1000 S. Paca st.

N B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. PHYSICIAN should be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Garrett)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87734 ✓

D 87734

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 N. Stricker ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Gorrett

(a) RESIDENCE NO. 1102 N. Stricker ST., WARD

(Usual place of abode) whole life (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
62	62	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Collector for Life Ins. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City Md.

PARENTS

10 NAME OF FATHER Richard Gorrett

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Chester A. Gorrett

(Address) 1102 N. Stricker St

15 Filed JUN 1 01924 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20 1923 to June 8 1924,

that I last saw him alive on June 7 1924,

and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

about

(duration) 1 yr. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chem. & micro

(Signed) Chas. L. McCardell, M. D.

6-9 1924 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. M. Auburn	June 11 1924
20 UNDERTAKER	ADDRESS
Sam'l. H. Greenhow's	1400 Mosher

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87735

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 87735

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 Pine St. Ward)

2-FULL NAME Kate Prince

(a) RESIDENCE NO. 638 Pine ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John H Prince

6 DATE OF BIRTH (month, day, and year) May 5 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS
10 NAME OF FATHER Horace Blake
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.
12 MAIDEN NAME OF MOTHER Fossie Handy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John H Prince
(Address) 638 Pine St.

15 JUN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from March 18 1924, to June 8 1924, that I last saw h alive on June 6 1924 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Probably Syphilitic)
(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) ... yrs. 4 mos. ... ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Microscopic Exam.
(Signed) [illegible] M. D.
6/12/24 19 (Address) 908 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Georgetown, Kent Co., Md. DATE OF BURIAL June 11, 1924

20 UNDERTAKER Mrs. Katie R. Williams ADDRESS 322 N. Schroeder St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87736

CERTIFICATE OF DEATH.

57

D 87736

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1910 Poplar Grove St. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H.Hammond.

(a) Residence No. 1910 Poplar Grove St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Louisa C.Hammond.

6-DATE OF BIRTH (month, day and year) Nov.16.1849

7-AGE. 74 yrs. 6 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cabinet Maker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Washington Co.Md.

PARENTS.

10-NAME OF FATHER John Hammond,

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Louisa C.Hammond,

(Address) 1910 Poplar Grove St.

Filed JUN 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). JUN 9 1924

17- I HEREBY CERTIFY, That I attended deceased from January 2nd, 1923., to June 10th, 1924.,

that I last saw him alive on June 9th, 1924.,

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(Duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation

(Signed) Wm Leonard Bowie, M. D.

JUN 9, 1924 (Address) 1900 Maryland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Western Cem. DATE OF BURIAL, JUN 13 1924, 19....

20-UNDERTAKER. Geo W Little ADDRESS 2700 Pennsylvania Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87737 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87737

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. Provident Hospital St., 16 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Diggs

(a) RESIDENCE No. 832 N. Carey St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Libria Africa

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Mrs Lyons
(Address) 728 N Carey St

15 JUN 11 1924 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1924, to June 8, 1924

that I last saw her alive on June 8, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Multinodular Fibroma uteri
+ Chronic Appendicitis
(duration) yrs. — mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia
(duration) — yrs. — mos. — ds.

18 Where was disease contracted, if not at place of death? 832 N. Carey St

Did an operation precede death? yes Date of May 24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) S B Hughes, M. D.

June 10, 1924 (Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	June 11 1924
20 UNDERTAKER	ADDRESS
John H. Trodden	1422 Pitcher St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87738

CERTIFICATE OF DEATH.

90 D 87738

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 626 East Fort St., W. WARD)

2-FULL NAME John Thomas Copper

(a) RESIDENCE (Usual place of abode) No. 626 East Fort Ave ST., ... WARD .....

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda Copper

6 DATE OF BIRTH (month, day, and year): 11-21-1859

7 AGE — Years: 64 — Months: 7 — Days: 17 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ry Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md

PARENTS

10 NAME OF FATHER: Cyrus Copper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Drucilla Hurlock

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Matilda Copper (Address) 626 E Fort Ave.

15 JUN 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1924

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to June 8, 1924.

that I last saw him alive on June 7, 1924,

and that death occurred, on the date stated above, at 2:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

6/8/24 (Signed) E. E. Buxton M. D.

(Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: 6-11 1924

20 UNDERTAKER: E. T. Burke — ADDRESS: 115 E West St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

17182 B 87739 — B 87739 — 40

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard E. Chase

(a) RESIDENCE NO. 4th Ave Fairfield WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): April 7, 1924

7 AGE — Years: — Months: 1 Days: 21 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): H

(c) Name of employer: H

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George E. Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lennie Middleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30, 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1924 to May 30, 1924 that I last saw him alive on May 30, 1924 and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

acute Gastro-intestinal indigestion

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) pneumococcal Opthalmitis

(duration) ..... yrs. 1 mos. 22 ds.

18 Where was disease contracted if not at place of death? at home (Parents)

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological examination

(Signed) Cason Callis, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19 .

20 UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87740

CERTIFICATE OF DEATH.

NY-091 D 87740

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Wilson

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 640

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed JUN 11 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9 1924

17 I HEREBY CERTIFY, That I attended deceased from 10-19, 1921, to 6-9, 1924 that I last saw him alive on 6-9, 1924, and that death occurred, on the date stated above, at 3:15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Hypertension

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub

(Signed) Claude G. Wilson, M. D.

6-9, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 6/11 1924

20 UNDERTAKER Philip Herrig

ADDRESS 2016 Orleans

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87741 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87741

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 N. Bidle St., 11 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Watkins

(a) Residence No. 307 N. Bidle St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE. Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Burnett Watkins

6-DATE OF BIRTH (month, day and year) 1886.

7-AGE. 48 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private family

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. James Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Harriet Upyndon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14-(Informant) Burnett Watkins

(Address) 307 N. Bidle St

15-Filed JUN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 9. 1924

17-I HEREBY CERTIFY, That I attended deceased from Apr 1, 1924 to June 9 1924 that I last saw h.. alive on June 9 1924 and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

Intestate

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of May 14

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex —

(Signed) R. Gadard Thomas M. D.

June 11, 1924 (Address) 1534 N. Bidle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. June 11, 1924

20-UNDERTAKER. Samuel Grady

ADDRESS 1537 N. Bidle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87742

CERTIFICATE OF DEATH.

12 D 87742

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 681 Vine ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Hackley

(a) RESIDENCE No. 681 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont know

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Ben Hackley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sara Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Butts

14 Informant Sarah Hackley

(Address) 681 Vine St

15 Filed JUN 11 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1924

17 I HEREBY CERTIFY, That I attended deceased from Jn 7, 1924, to Jn 9, 1924, that I last saw him alive on Jn 8, 1924, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis

Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical Symptoms

(Signed) R B Thompson, M. D.

Jn 9, 1924 (Address) 607 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 12 1924
20 UNDERTAKER	ADDRESS
Mrs R. C. Elliott	1725 Eastland

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87743

CERTIFICATE OF DEATH.

159-002 D 87743

1-PLACE OF DEATH. (a) Farm near Reisterstown Rd. REGISTERED NO.

CITY OF BALTIMORE: (No. Bucks Lane ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard William Corfield

(a) RESIDENCE. NO. Bucks Lane ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1/2 dy. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9/24.

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Chelsea Corfield.
11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.
12 MAIDEN NAME OF MOTHER Virgie May Parks.
13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Thomas Chelsea Corfield
(Address) Bucks Lane.

15 JUN 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 10, 1924, that I last saw h— alive on June 10, 1924, and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Infantile Cardiac Weakness.

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Adrenal Insufficiency.

(duration) yrs. mos. 1/2 dy.

18 Where was disease contracted if not at place of death? Bucks Lane.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. O. Corfield, M. D.

6/10/24 (Address) Park & Hughes Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Balto Co. DATE OF BURIAL: Jun 11 1924

20 UNDERTAKER: CHENOWETH & SON, ADDRESS: 1417 CHRISTMAS AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87744

CERTIFICATE OF DEATH.

440 87744

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1813 W. Mosher St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Meleska Brewer

(a) Residence No. 1813 W. Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Brewer

6-DATE OF BIRTH (month, day and year) Sept. 3, 1876

7-AGE,	If LESS than 1 day,
47 yrs. 9 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Maryland

PARENTS.

10-NAME OF FATHER: Edward D. Clark

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Maryland

12-MAIDEN NAME OF MOTHER: Irene Gray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland

14- (Informant) George E. Brewer

(Address) 1813 W. Mosher Street

15- Filed JUN 11 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 10, 1924

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to June 10 1924

that I last saw h[illegible] alive on June 10, 1924

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver following removal of Right Breast 3 Mos. previous

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May - 1923

Was there an autopsy? yes

What test confirmed diagnosis? Pathologic[illegible]

(Signed) Madison W. Shook M. D.

6-10. 1924 (Address) 806 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Loudon Park Cem	June 12, 1924
20-UNDERTAKER.	ADDRESS
Joseph B Cook	1003 W Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87745

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87745

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 N. Carey ST., 19 WARD)

2-FULL NAME Wilhelmina Von Kritzel

(a) RESIDENCE NO. 320 N. Carey ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Von Kritzel

6 DATE OF BIRTH (month, day, and year) May 26, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	--	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germantown, Pa

PARENTS

10 NAME OF FATHER Charles Krey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Reuter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Bertha Von Kritzel
(Address) 320 N. Carey St.

15 JUN 11 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 9, 1924, that I last saw her alive on June 9, 1924, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Arteriosclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frank H. Mackie, M. D.

6-11 1924 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL June 13, 1924

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 87746

D 87746

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 15 WARD)

2-FULL NAME Mrs. Hattie White

(a) RESIDENCE NO. 2816 Kate Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham White

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER David Lindenborn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rachel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. A. Lindenborn (Address) 2816 Kate Ave.

15 JUN 11 1924 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1924, to June 10, 1924, that I last saw h.er alive on June 10, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Acute streptococcus infection

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isidore L. Levy, M. D.

June 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem.

DATE OF BURIAL 6/12/1924

20 UNDERTAKER David Londheim

ADDRESS 118-20 W. Mt. Royal Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87747

CERTIFICATE OF DEATH.

74-001

D 87747

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 Batavia ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise H Huber

(a) RESIDENCE NO. 37 Batavia ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Huber

6 DATE OF BIRTH (month, day, and year) April 17th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country) N. Y.

PARENTS

10 NAME OF FATHER Frederick W. Cordes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Fredericka Von Boden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Amanda Huber (Address) 37 Batavia ave

15 Filed JUN 11 1924 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1924 to June 10th, 1924, that I last saw h alive on June 10th, 1924, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claus Schmick M. D.

6/10/24 (Address) 4 West Hoffman Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mathews Cemetery	June 13th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87748

CERTIFICATE OF DEATH.

D 87748

1-PLACE OF DEATH Union Memorial Hospital REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mr Coleman Rogers

(a) RESIDENCE No. Hagerstown, Md ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Letetia C. Rogers

6 DATE OF BIRTH (month, day, and year) Sept. 29 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	9	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Dr. J H. Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky

12 MAIDEN NAME OF MOTHER Abigal Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant (Address) Mrs. Letetia C. Rogers Hagerstown Md

15 Filed JUN 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 1924

17 I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1924, to June 11, 1924.
that I last saw him alive on June 11, 1924,
and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder
metastases to lung.

(duration) (2) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyelonephrosis & Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes. Date of May 3rd
Was there an autopsy? Yes.
What test confirmed diagnosis?

(Signed) A B. Price, M. D.
, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	June 11 1924
20 UNDERTAKER Wm J Rickenbaugh	ADDRESS Nodh Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

171431 D 87749

CERTIFICATE OF DEATH.

49 D 87749

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

2-FULL NAME Rosa Byrd

(a) RESIDENCE No. 224 Jasper St., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T Byrd

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Harriet Thompson

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Rosa (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 11 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1924. to June 10, 1924.

that I last saw h.. alive on June 10, 1924.

and that death occurred, on the date stated above, at 12.00 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder

Uraemia

(duration) yrs. 6 mos ds. prob

CONTRIBUTORY (Secondary) Chronic Nephritis

Pyelonephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry J. Davis M. D.

19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-13 1924

20 UNDERTAKER Daniel Eurbert

ADDRESS 916 E Lane

Spec.—6-9-19—H. P. Co.—1000 Blks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87750

CERTIFICATE OF DEATH.

11-002 ✓

D 87750

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 Forrest ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Lee

(a) RESIDENCE. No. 306 Forrest ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo Johns

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Hester Burns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Undertaker

(Address) Mrs R A Elliott 1725- Ashland Ave

15 Filed JUN 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1924

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to June 8, 1924, that I last saw h.. alive on June 8, 1924, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Inflamatory Rheumatic Fever

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Old, Grippe Infection

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns, M. D.

6-11-24 (Address) 2017 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 11. 19 24
20 UNDERTAKER	ADDRESS
Mrs R A Elliott	1725- Ashland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87751

CERTIFICATE OF DEATH.

38 D 87751

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Greenmillow St. ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

2-FULL NAME Gannett Johnson

(Residence in Baltimore—No. 632 Greenmillow St — St.; ..... yrs., 4 mos. 10 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on beck of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Single

6-DATE OF BIRTH, June (Month) 1st (Day), 1924 (Year)

7-AGE, ... yrs. 4 mos. 10 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto - Md

PARENTS.

10-NAME OF FATHER, Albert Johnson

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Harriet Robinson

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriet Johnson

(Mother) (Address) 632 Greenmillow St.

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

JUN 11 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1924 to June 11 1924, that I saw her alive on June 10 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (Duration) ... yrs. ... mos. 7 ... ds.

CONTRIBUTORY (Secondary) Hereditary Lues

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. E. Wells M. D.

June 11..., 1924 (Address) 1443 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 191...

20-UNDERTAKER | ADDRESS

JUN 11 1924

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1723 86 87752

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87752

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME Anna Katherine Knatz

(a) RESIDENCE No. St. Vincents Orphan Asylum WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Jan 3rd 1924

7 AGE — Years: — Months: 5 Days: 8

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: F. Hoffman Knatz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Helen Anna Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 Robert P. Harrison Registrar

JUN 11 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1924 to June 11, 1924 that I last saw her alive on June 11, 1924 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Nasal diphtheria

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? St Vincents

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Nasal culture

(Signed) A. A. Weech M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem DATE OF BURIAL: June 11 1924

20 UNDERTAKER: Jas B Cook ADDRESS: 1003 N Balto

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87753

90 D 87753

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 Hanover St. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha E. Thater.

(a) RESIDENCE No. 1022 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 60 yrs. ---- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widow.

5a If married, widowed, or ~~divorced~~ (or) WIFE of Philip C. Thater

6 DATE OF BIRTH (month, day, and year) March 2, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER George Traband.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Sophia H. Plitt. (daughter) (Address) 1022 Hanover St.

15 JUN 11 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 10, 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 12th. 1924 to June 10th. 1924.

that I last saw h. e. alive on June 10th. 1924.

and that death occurred, on the date stated above, at h. 85 h m.

The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart and Kidneys.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? --------

Did an operation precede death? No. Date of -----

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

6/12 24 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 13 1924
20 UNDERTAKER E. Schlosman & Son	ADDRESS 1039 Hanover

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 12068 D 87754 — + 65 D 87754

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Samuel L. Austin

(a) RESIDENCE NO. Bishopville, S. C. WARD Bishopville S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Mrs. Ethel Austin

6 DATE OF BIRTH (month, day, and year) Sept 11, 1883

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Marcus M Austin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Mary McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Recado
(Address) JOHNS HOPKINS HOSPITAL

15 FILED JUN 11 1924 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to June 11, 1924, that I last saw him alive on June 11, 1924, and that death occurred, on the date stated above, at 12.25 P m.

The CAUSE OF DEATH* was as follows:

Hodgkin's disease

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Trevor Owen, M. D.

June 11th 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg S.C. | DATE OF BURIAL June 1924

20 UNDERTAKER E. LeRoy Stiffler | ADDRESS 1554 North Calvert

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 11 1924

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 87755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maternity Franklin Square Hospital

CITY OF BALTIMORE: No 1603 Holbrook st. ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgia R. Hokamp.

(a) RESIDENCE No 1603 Holbrook. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert A. Hokamp.

6 DATE OF BIRTH (month, day, and year) July. 18 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	18	10.	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city (State or country) Md.

PARENTS

10 NAME OF FATHER James N. Orr.

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Reynolds

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Stella Orr. (Address) 1603 Holbrook st.

15 Filed JUN 11 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 9. 1924

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1924, to June 9, 1924, that I last saw her alive on June 9, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Eclampsia, Childbirth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. 7m mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes What test confirmed diagnosis? Autopsy & Biopsy

(Signed) W. A. Darlington M. D.

, 19 (Address) 3101 Oakfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden.	6/12. 1924
20 UNDERTAKER Walter Davis	ADDRESS 3307 Pa. Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87756

CERTIFICATE OF DEATH.

16 D 87756

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maty-Drexel Lg. Hosp St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Hathaway

(Residence in Baltimore: No. 1603, Hillsdale St St.; yrs., moe. 1 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
M	White	Sing.

6-DATE OF BIRTH, 6 - 9 - 24, 1
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 23 hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....—
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Albert Hathaway

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Bessie Dew

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hospital Record

(Address).....

15- JUN 1 1924 Robert P. Harrison,
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1924, to June 10 1924, that I saw her alive on June 9 1924, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) W. A. Dinsley M. D.

June 10, 1924 (Address) 3101 Auf

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 23 hrs. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Mary's Lampden	6/12....., 1924
20-UNDERTAKER Walter Davis	ADDRESS 3307 Ra

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87757

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87757

10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1450 Stevenson St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Berwinkler (Berwunkler)

(a) Residence No. 1450 Stevenson St. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Aug 4 - 1920

7-AGE. 3 yrs. 10 mos. 7 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Joseph Berwinkler.

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Styland.

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Margaret Berwinkler

(Address) 1450 Stevenson St.

15- Filed JUN 11 1924, 19.. Robert P. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11 - 1924

17- I HEREBY CERTIFY, That I attended deceased from June 3 1924 to June 11 1924 that I last saw h.. alive on June 10 1924 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Diphtheria (carrier)

(Duration) ..... yrs. ..... mos. 8 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Health Dept. Exam.

(Signed) Thos A Stevens M. D

6/11, 1924 (Address) 2878 Huntford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Brooklyn — DATE OF BURIAL, June 12 19..

20-UNDERTAKER Felix Zeile — ADDRESS 403 S. Wolfe St.

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING. Typewriter 9-22-21

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Marian Gott)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 87758

CERTIFICATE OF DEATH. X 84 D 87758

1-PLACE OF DEATH Church Home Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. N. Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Gott

(a) RESIDENCE NO. 5 Franklin ST., WARD Annapolis Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 10 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Winsan T. Gott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marion Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant Winsan T. Gott
(Address) Annapolis Md

15 Filed JUN 11 1924, 19 Robert F. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1924, to June 11, 1924, that I last saw her alive on June 11, 1924, and that death occurred, on the date stated above, at 11.10 A.M.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? YES Date of June 10.

Was there an autopsy? YES.

What test confirmed diagnosis? Clinical evidence

(Signed) Captain [illegible], M. D.

, 19 (Address) Calvert Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	June 11 1924
20 UNDERTAKER	ADDRESS
Jas S. Sayler Sons	Annapolis Md

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-0B3 ✓ 87759

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Colonial Hospital St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Robert Vinci

(Residence in Baltimore: No. 2915 Harlem ave St. 1/2 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (Write the word.)
Male.	White	Singe

6-DATE OF BIRTH. Oct (Month) 12th (Day) 1916. (Year)

7-AGE. 7 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Pietro Vinci

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Anna Glorioso

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pietro Vinci

(Address) 2915 Harlem ave

15. Robert P. Harrison,

Filed ..... 192.. Burial Permit Clerk. Registrar.

JUN 11 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 9th (Month) (Day) 1924. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) automobile accident

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner)

June 10 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral Cemetery	June 12 1924

20-UNDERTAKER, George J. Ruth ADDRESS 1735 Harford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

No. 8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-28—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87760

CERTIFICATE OF DEATH.

D 87760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1814 East Oliver ST., 8 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H Freyer

(a) RESIDENCE No. 1814 East Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Margaret A Freyer

6 DATE OF BIRTH (month, day, and year) March 20. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cement Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Siderachs 83
(c) Name of employer Self Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles Freyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Margaret A Freyer
(Address) 1814 East Oliver St

15 [illegible] 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Collins, M. D.
(Coroner.)

6/11/ 1924 (Address) 508 [illegible] Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 13, 1924
20 UNDERTAKER	ADDRESS
John Cook	502 E Fort Ave

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 1 1924

Cor.—1-12-23—M&T—100 Blks.

D 87761

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87761

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 20 WARD)

2-FULL NAME Joseph M. Harrison

(a) RESIDENCE NO. 307 Fawkes St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Madama Harrison

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman Test Dept
(b) General nature of industry, business, or establishment in which employed (or employer) Gas Fitter
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jos M. Harrison

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Willie P. Haney

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Joseph M. Harrison
(Address) 1502 Hollins St.

15 Filed JUN 11 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 9 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. A long time mos. ..... ds.

CONTRIBUTORY (Secondary) Bursa on body

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Geraldy, M. D.
(Coroner)

6-11, 1924 (Address) 107 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Jan 12 1924

20 UNDERTAKER Harry H. Weitz ADDRESS 1534 W Lombard St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87762

CERTIFICATE OF DEATH.

90 D 87762

1-PLACE OF DEATH U.S. Marine Hospital No. Baltimore Md. 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Charles Lava.

(a) RESIDENCE NO. U.S. Marine Hospital No. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 1886

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S/S Virginia

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Self.

(Address) Baltimore Md.

15 JUN 12 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 7, 1924 to June 8, 1924

that I last saw him alive on June 8, 1924,

and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Interstitial Nephritis.

Valvular Disease of Heart.

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. C. Graves. M. D.

6/8, 1924 (Address) U.S. Marine Hospital No. Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL 6/11, 1924

20 UNDERTAKER Sol Linsman & Bro

ADDRESS 1127 E Balto St

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87763

CERTIFICATE OF DEATH.

100-001 D 87763

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1304 Eutaw Place St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Robt A. Taylor

(a) Residence No. 1304 Eutaw Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed,~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) November 5th 1846

7-AGE, 77 yrs. 7 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)..... Business

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, William W. Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER, Catherine Augusta Birchhead

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Henry W. Jenkins Sons Co

(Address) 502 Cathedral St

15- Filed JUN 12 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 10/24

17- I HEREBY CERTIFY, That I attended deceased from May 19 - 19 24 to June 10 19 24

that I last saw him alive on June 10, 19 24

and that death occurred, on the date stated above, at 4 15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) 6 yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cystitis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Evidence

(Signed) [illegible], M. D.

, 19 (Address) 458 Cathedral St 143 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount — DATE OF BURIAL, June 12 19 24

20-UNDERTAKER, Henry W. Jenkins Sons Co — ADDRESS Richard & McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87764

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 100 Evergreen ave St., Hamilton Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Charles H. Cursey.....

(a) Residence No. 100 Evergreen ave St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J Cursey

6-DATE OF BIRTH (month, day and year) July 4 1852

7-AGE, 71 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)..... Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Henry Cursey

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Hailes

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14-

(Informant) Henry A. H. Prow

(Address) 100 Evergreen ave

15- JUN 1 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 9-1924

17- I HEREBY CERTIFY, That I attended deceased from Aug 17, 1923 to June 9, 1924

that I last saw him alive on June 2, 1924

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 1 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

6/10, 1924 (Address) Hamilton Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Unionville Md. DATE OF BURIAL, June 12 1924

20-UNDERTAKER, W M Routson ADDRESS 2238 N Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87765

CERTIFICATE OF DEATH.

3 D 87765

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Steele

(a) Residence No. 808 W. Pratt st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1884

7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Samuel Steele

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town): (State or Country) Unknown

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed JUN 1 2 1924 192. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 23 1924 to June 11 1924

that I last saw him alive on June 11 1924

and that death occurred, on the date stated above, at 5.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D

6-11 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Peters Cemetery	June 13 1924
20-UNDERTAKER	**ADDRESS**
Jones & Lawson	12 N. Green St

Spec—12-23-21—E.B R.S.—400 Bks.

Dr Metzel, 1903 W North Ave (Mod 2326)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87766

CERTIFICATE OF DEATH.

90 D 87766

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 704 North Calhoun St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Lingg

(a) Residence No. 704 North Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jennetta Lingg

6-DATE OF BIRTH (month, day and year) Apr 14, 1840

7-AGE,	If LESS than 1 day,
84 yrs. 1 mos. 21 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Self 080

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna

PARENTS

10-NAME OF FATHER, Nicholas Lingg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-INFORMANT (Informant) Harry M Lingg

(Address) 704 No Calhoun St

15-FILED JUN 12 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12. 1924

17- I HEREBY CERTIFY, That I attended deceased from June 7 1924 to June 12, 1924

that I last saw him alive on June 11, 1924

and that death occurred, on the date stated above, at 2.9 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) R. L. Metzel M. D.

June 12, 1924 (Address) 1903 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral	June 13 1924

20-UNDERTAKER,	ADDRESS
Wm Cook	502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec–12-23-21–E.B.R.S.–400 Bks.

D 87767

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 D 87767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 N. Fulton Ave St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret H. Woods

(a) Residence No. 1108 N Fulton Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 56 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pa.

PARENTS.

10-NAME OF FATHER Frank Woods

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Coogan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-(Informant) Mrs John H. Kaufman

(Address) 1108 N. Fulton Ave

15-Filed JUN 12 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 10 1924

17-I HEREBY CERTIFY, That I attended deceased from June 3 1924 to June 10 1924

that I last saw h.. alive on June 10 1924

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension ?

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Kaufman M. D

6/11/24 (Address) 1111 Cleveland St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery DATE OF BURIAL. June 13, 1924

20-UNDERTAKER. Henry Koch & Son ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

Spec– 12-23-21– E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87768

CERTIFICATE OF DEATH.

91-00

D 87768

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1775 Montpelier St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Luber

(a) Residence No. 1775 Montpelier St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, ~~or Divorced~~. (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of The late John Luber

6-DATE OF BIRTH (month, day and year) Dec 25th 1843

7-AGE. 81 yrs. 6 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS

10-NAME OF FATHER, George Kriger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Josephine —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Mrs. Thomas J. Hughes

(Address) 1775 Montpelier St

JUN 12 1924

Filed

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11th 1924

17- I HEREBY CERTIFY, That I attended deceased from April 24 1924 to June 11 1924

that I last saw her alive on June 11 1924

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Cerosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? nv Date of

Was there an autopsy? nv

What test confirmed diagnosis?

(Signed) Geo. Lightenmann M. D

6/11 1924 (Address) 1254 Hanford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cemetery — DATE OF BURIAL. June 14 1924

20-UNDERTAKER, Henry Kruck & Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87769

188-008

D 87769

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene B Rhodes

(a) RESIDENCE NO 434 N Carrollton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Rhodes

6 DATE OF BIRTH (month, day, and year) Mar 3 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm Rhodes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co

12 MAIDEN NAME OF MOTHER Annie Reiley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co

14 Informant Wm E Rhodes
(Address) 511 N Bethesda St

15 Filed JUN 1 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Fall

Fracture of Skull (Cor.)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. 6 ds.

(Signed) Geo Claus m Rhodes M. D.
(Coroner.)

6/11/24 192 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	June 12 1924
20 UNDERTAKER Wm Cook	ADDRESS 582 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87770

100-001

D 87770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 823 S. Port St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benedykt Foltyn

(a) Residence No. 823 S. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 21 1923

7-AGE.	If LESS than 1 day,
1 yrs. 2 mos. 21 ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER Stephen Foltyn

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country).

12-MAIDEN NAME OF MOTHER, Anastasia, Gutowski

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country).

14- (Informant) Mr Stephen Foltyn

(Address) 823 S. Port Street

15- JUN 1 2 1924 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11 1924

17- I HEREBY CERTIFY, That I attended deceased from May 25 19 24 to June 11, 19 24

that I last saw h. alive on June 10 19 24

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) — yrs. — mos. 17 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Petterson M. D

, 19 (Address) 817 Hamilton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 13. 1924
20-UNDERTAKER.	ADDRESS
John McWeber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8777E

D 8777E

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1213 Brevard ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Hicks

(Residence in Baltimore: No. 1213 Brevard St.; 10 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) 1863 (Year)

7-AGE, 61 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE, (State or Country), Chesterfield Md.

PARENTS.

10-NAME OF FATHER, Peter Floyd

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Floyd

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Floyd

(Address) 1213 Brevard St.

15- Filed ....., 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

JUN 12 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10, 1924 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1924, to June 10 1924, that I saw her alive on June 9 1924, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

?

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion & Debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Stuckey M. D.

6 10, 1924 (Address) 637 Mosher St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Chesterfield Md.

DATE OF BURIAL, June 13, 1924

20-UNDERTAKER J. Wm. P. G. Elliott

ADDRESS 1725 Eastlandon

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87772

CERTIFICATE OF DEATH.

1 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Main or Mt Washington ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Morrison Stonecipher

(a) RESIDENCE NO. 1226 Main ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Stonecipher

6 DATE OF BIRTH (month, day, and year) Oct. 14-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	1862	oct 8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bridge carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer Harry Mewshaw

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nelson Stonecipher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillie Krantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sarah E Stonecipher

(Address) 1226 Main St Mt Washington

15 JUN 1 21924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11- 1924

17

I HEREBY CERTIFY, That I attended deceased from 5-25, 1924, to 6-8, 1924, that I last saw him alive on 6-8, 1924, and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) J B Hall, M. D.

, 19 (Address) Hazelhurst

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Dec DATE OF BURIAL June 14 1924

20 UNDERTAKER Joseph B. Orth ADDRESS 1005 W. Baltimore St.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87773

CERTIFICATE OF DEATH.

129 D 87773

1-PLACE OF DEATH

City of BALTIMORE: (No. 236 N. Payson St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Mitchell

(a) Residence No. 236 N. Payson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie L. Mitchell

6-DATE OF BIRTH (month, day and year): Sept 29–1861

7-AGE: 62 yrs. 8 mos. 13 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Beef Business

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Delaware

PARENTS

10-NAME OF FATHER: John W Mitchell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa.

12-MAIDEN NAME OF MOTHER: Sarah A. Beatty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-

(Informant): Mrs Helen Beyer

(Address): 236 N Payson St.

15-

Filed JUN 12 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 11–1924

17- I HEREBY CERTIFY, That I attended deceased from Sept – 1, 1923, to June 11, 1924, that I last saw him alive on June 10, 1924, and that death occurred, on the date stated above, at 5:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urinary

(Signed) Walter W Shoaf, M. D.

June 16, 1924 (Address) 806 W Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge Cemetery	June 23 1924
20-UNDERTAKER	**ADDRESS**
Chas F. Evans & Son	118 W Mt Royal Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87774

CERTIFICATE OF DEATH.

74-B 87774

1-PLACE OF DEATH

City of BALTIMORE: (No. 1815 Eutaw Place St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Sidney Newhoff

(a) Residence No. 1815 Eutaw Place Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Oct 13/1885

7-AGE, 38 yrs. 7 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)..... Cotton Goods

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Max Newhoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Rosa Frank

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14-

(Informant) Anna Newhoff

(Address) 1811 Eutaw Place

15-

Filed JUN 12 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 22d, 1921, to June 11, 1924, that I last saw h.e alive on June 11, 1924, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis — Uremia

(Duration) 3 yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger M. D.

June 12, 1924 (Address) 1207 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew — DATE OF BURIAL. June 13 1924

20-UNDERTAKER. Harry Goodheim — ADDRESS 118 W. Lafayette

A—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87775

100-001

D 87775

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 S Poppleton St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Mazziglia

(a) Residence No. 309 S Poppleton St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 16 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 21 23

7-AGE. ..... yrs. 10 mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Mazziglia

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Mary Phillips

13-BIRTHPLACE OF MOTHER (city or town) Md. (State or Country),

14- (Informant) Charles Mazziglia

(Address) 309 S Poppleton

15- FILED JUN 13 1924 ROBERT R. KRAUS, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 1924

17- I HEREBY CERTIFY, That I attended deceased from June 9, 19 24, to June 12, 19 24,

that I last saw her alive on June 12, 19 24,

and that death occurred, on the date stated above, at 12.15 p. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia (Primary)

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam.

(Signed) S Thaxton Linn, M. D.

6/12/24 (Address) 888 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	June 13, 1924
20-UNDERTAKER. J. W. M. Routson	ADDRESS 2238 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87776

CERTIFICATE OF DEATH.

D 87776

1-PLACE OF DEATH Howard A Kelly Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Eutaw Pl ST. 78 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Amelia V. Huson.

(a) RESIDENCE NO. 4305 Penhurst Ave ST., West Arlington WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Thomas F. Huson.

6 DATE OF BIRTH (month, day, and year) Aug 11-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53 yrs	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Jacob Kaufman.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Sarah K. Benner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: Thomas F. Huson (Husband)

(Address) 4305 Penhurst Ave

15 Filed JUN 1 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to June 12, 1924, that I last saw h.. alive on June 12, 1924, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Carcinoma breast

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? 1418 Eutaw Pl.

Did an operation precede death? Yes Date of May 26'24

Was there an autopsy? No.

What test confirmed diagnosis? Bacteriological

(Signed) Grant Ward, M. D.

. 19 (Address) 1418 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster St Benjamins

DATE OF BURIAL: June 14 1924

20 UNDERTAKER: W M Routson

ADDRESS 2258 N Smith

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 87777

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 3305 Paine St.

CITY OF BALTIMORE (No.) 3305 Paine ST. 13 (WARD)

2-FULL NAME Charles Shaffer

(a) RESIDENCE NO. 3305 Paine St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. 3 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22/1877.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47.	3.	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland.

PARENTS

10 NAME OF FATHER Adam Shaffer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Catherine Hoover.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant (Address) Mrs Lavony Walk. 3305. Paine St.

15 JUN 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 11 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 11, 1924, that I last saw him alive on June 10 1924 10 A.M. and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examn

(Signed) H A Darby, M. D.

, 19 (Address) 3101 Oakfield

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cem Hamsted DATE OF BURIAL 6/13. 1924

20 UNDERTAKER J. WALTER DAVIS FUNERAL DIRECTOR ADDRESS 3307 Paine St

J W Davis

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87778

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., ...WARD)

2-FULL NAME Kath Rommel

(a) RESIDENCE NO. 1840 E. Chase ST., ...WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced — HUSBAND of (or) WIFE of: Charles Rommel

6 DATE OF BIRTH (month, day, and year): Nov 9-1884

7 AGE — Years: 40 — Months: 7 — Days: 3

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: — Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Brauch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas F. Rommel
(Address) 1840 E. Chase

15 JUN 7 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 11, 1924, that I last saw h[illegible] alive on June 11, 1924, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) — yrs. — mos. 19 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Blair Lowan, M. D.

(Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: June 13 1924

20 UNDERTAKER: Robt J Rimes — ADDRESS: [illegible] W. Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87779

CERTIFICATE OF DEATH.

123 D 87779

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., ... WARD)

2-FULL NAME Mrs Pauline Nelson

(a) RESIDENCE NO. 2747 Alameda ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Nelson

6 DATE OF BIRTH (month, day, and year) 1854-Dec 8

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
74	6	3	

8 OCCUPATION OF DEGEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John May

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mathilda Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record
(Address)

JUN 13 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/24

17 I HEREBY CERTIFY, That I attended deceased from 6/4/24, 19..... to 6/11/24, 19.....
that I last saw her alive on 6/11/24, 19.....
and that death occurred, on the date stated above, at 3.05 a m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Gangrene of Gall Bladder

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Cholecystectomy

Did an operation precede death? Yes Date of 6/9/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Goldsborough, M. D.

6/12 1924 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	June 14 1924
20 UNDERTAKER	ADDRESS
A. Sander Sons	1710 Eutaw St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 87780

D 87780

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 N. Bruce St. ; ST., 16 WARD)

2-FULL NAME Thomas ~~Dobkin~~ Gross

J.T.H.

(a) RESIDENCE NO. 630 N. Bruce St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

J.T.H.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 COLOR OR RACE ~~white~~ colored

5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3, 1924 guess

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER David Gross

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Clara Smith

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant David Gross
(Address) 630 N. Bruce St.

15 JUN 1 3 1924

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

(Address) June 12 1924 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. W. Lindenmeyer Son

DATE OF BURIAL 6/13/24

20 UNDERTAKER Daniel Carlos

ADDRESS 96 6a av

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 87781

CERTIFICATE OF DEATH.

12 D 87781

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Fulford Ave. St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gallagher.

(a) RESIDENCE NO. 1817 Fulford Ave. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — John Gallagher.

6 DATE OF BIRTH (month, day, and year) Oct. 31st 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	57.	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Mulroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Burns.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Mamie Mousaw

(Address) 1817 Fulford Ave.

JUN 1 3 1924

ROBERT R. KRAUTER, Clerk.

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/20, 1924, to 6/11, 1924.

that I last saw h[illegible] alive on 6/11, 1924

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. 8 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr Benson Hood, M. D.

6/11, 1924 (Address) 914 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Rd. DATE OF BURIAL June 13th 1924

20 UNDERTAKER John J. Cowan Mod. ADDRESS 901 Bolton St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87782

CERTIFICATE OF DEATH.

43 D 87782

1-PLACE OF DEATH SOUTH BALTO GEN'L HOSP No

CITY OF BALTIMORE: (No. 1213 LIGHT ST., WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME WILLIAM ZIPPLING.

(a) RESIDENCE NO. 321 S. CLINTON ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
MALE	WHITE	SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) JAN 26, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Night Watchman
(b) General nature of Industry, business, or establishment in which employed (or employer) Pork Packer.
(c) Name of employer Schluderberg-Kurdle

9 BIRTHPLACE (city or town) BALTIMORE
(State or country) MD

PARENTS

10 NAME OF FATHER JULIUS ZIPPLING

11 BIRTHPLACE OF FATHER (city or town) GERMANY
(State or country)

12 MAIDEN NAME OF MOTHER MARY SHOEMAKER

13 BIRTHPLACE OF MOTHER (city or town) BALTO
(State or country) MD

14 Informant AUGUSTA ZIPPLING
(Address) 321 S. CLINTON ST

JUN 1 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUNE 11, 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 11, 1924, that I last saw him alive on June 11, 1924, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Paresmans of Larynx
Lips
(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Oedema
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/11/24

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. A. K. Davison, M. D.

6/13 1924 (Address) 837 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	June 14, 1924
20 UNDERTAKER John Ellis	ADDRESS 2317 Ellam

ac- 12-23-21—E.B.R.S.—400 Bks.

D 87783 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87783

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 618 N. Decker ave ~~St.~~ 7 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Francis Durbin

(a) Residence No. 618 N. Decker ave ~~St.~~ Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug-26-1923

7-AGE. ..... yrs. 9 mos. 16 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, James J. Durbin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Minnie Glassberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14- (Informant) Mrs. Minnie Durbin

(Address) 618 N. Decker ave

15- Filed JUNT 3 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12-24

17- I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 12, 1924

that I last saw him alive on June 12, 1924

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Pleuropolitis

Convulsions (Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency, Edema Lungs (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 5414 Milton Ave, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL, June 13, 19 24

20-UNDERTAKER J. A. Inoran ADDRESS 3000 E. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D 87784

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 2422 N. Charles St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William D. Nelson Thomas

(a) Residence No. 2422 N. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. • How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Thomas

6-DATE OF BIRTH (month, day and year) Nov 23 1869

7-AGE 54 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Insurance Agent

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or town) St Marys Co Md
(State or Country)

PARENTS.

10-NAME OF FATHER James Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Fannie Nelson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Dr Douglas Thomas

(Address) 2739 N Calvert St

15-

Filed ..... 192.....

JUN 13 1924

ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 1924

17- I HEREBY CERTIFY, That I attended deceased from June 2 19 24 to June 12 19 24

that I last saw him alive on June 12 19 24

and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm J. Watson M. D.

June 13, 1924 (Address) 2128 St Paul

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. London Park June 14 1924

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87785

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87785

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — 1924 — Registered No. .....

City of BALTIMORE: (No. 2119 Brenton St., W. Mulberry 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis H Loney

(a) Residence No. 2119 Brenton St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rose McLaughlin Loney

6-DATE OF BIRTH (month, day and year) Aug 4 1841

7-AGE. 82 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Chas Loney

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs Daisy M Libbey (Address) 42 Mountmorris

15- ..... 192 ROBERT R. KRAUTER Registrar.

JUN 13 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1 1924 to June 13 1924 that I last saw h[illegible] alive on June 11 1924 and that death occurred, on the date stated above, at 6[16] A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas M Kieffer M. D.

June 13, 1924 (Address) 2320 Druid Blvd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. June 16, 1924

20-UNDERTAKER. John O. Mitchell

ADDRESS 1201 W Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—I-12-23—M&T—100 Bks.

87786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5/ ✓ D 87786

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 S. First St. Brooklyn St.; 25 WARD)

2-FULL NAME John W. Creager.

(a) RESIDENCE NO 135 S. First St. Brooklyn ST.; ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 1 mos. 24 ds. How long in U. S., if of foreign birth? ---- yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married

5a If married XXXXXXXXXXXXXXX HUSBAND of XXXXXXXX Catherine Creager.

6 DATE OF BIRTH (month, day, and year) April 17, 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor, 07
(b) General nature of industry, business, or establishment in which employed (or employer) Arundel Boat Club
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Peter Creager.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Catherine Creager. (wife)
(Address) 135 S. First St. Brooklyn.

JUN 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion.
Rheumatic Endocarditis.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

June 11, 1924 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 13 1924
20 UNDERTAKER John F. Denny	ADDRESS 716 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87787

CERTIFICATE OF DEATH.

D 87787

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Cedar, ST., Curtis Bay WARD)

2-FULL NAME Charles A Fambach

(a) RESIDENCE NO. 8 Cedar ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Fambach

6 DATE OF BIRTH (month, day, and year) Aug 5 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder 047

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Fambach

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Frise

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs Mary E Fambach
(Address) 8 Cedar st Curtis Bay.

15 ROBERT R. KRAUTER, Registrar

JUN 13 1924 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from May 21st, 1924, to June 12th, 1924

that I last saw h alive on June 11th 3.45 1924

and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
aczn

(duration) 4 yrs. 6 mos. 22 ds.

CONTRIBUTORY (Secondary) General Debility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Thos. B. Horton, M. D.

June 12th, 1924 (Address) Curtis Bay, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross M A Co.	June 14 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87788 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 87788

CERTIFICATE OF DEATH.

52 V

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2815 Harlem Av ST.: 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odd Travers

(a) RESIDENCE. No. 2815 Harlem Av. ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C Travers

6 DATE OF BIRTH (month, day, and year) Dec 28 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

PARENTS

10 NAME OF FATHER Richard Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartsoke Md

12 MAIDEN NAME OF MOTHER Louise Calloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartsoke Md

14 Informant Mr James C Travers (Address) 2815 Harlem Av

15 JUN 1 3 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1924

17 I HEREBY CERTIFY That I attended deceased from Jan, 1924, to June 10, 1924.

that I last saw h alive on June 10, 1924.

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy M. D.

June 13 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 13 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Lex

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—F.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87789

CERTIFICATE OF DEATH.

D 87789

1-PLACE OF DEATH

City of BALTIMORE: (No. 1219 S. Clinton St., 26 Ward)

Registered No. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Schwartz

(a) Residence No. 1219 S. Clinton St., 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-~~Single,~~ Married, Widowed, ~~or Divorced,~~ (~~Write~~ the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Schwartz

6-DATE OF BIRTH (month, day and year) Aug. 5 1847

7-AGE. 76 yrs. 10 mos. 7 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Lawrence Fitzel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant) Geary M Schwartz

(Address) 1217 S. Clinton

15-

Filed JUN 13 1924 192.... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 1924

17- I HEREBY CERTIFY, That I attended deceased from June 4 19 24 to June 12 19 24

that I last saw her alive on June 12 19 24

and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

6/12, 1924 (Signed) Francis B Tilton M. D.

(Address) 315 S Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oakland Cem. DATE OF BURIAL. June 15 1924

20-UNDERTAKER. Zimbler & Zimbler ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 5-10-21 M&T 1500 Blks.

17464 D 87790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 D 87790

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME William Russel Ray

(a) RESIDENCE No. 1421 Anthony St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Feb 7? 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer ..... —

9 BIRTHPLACE (city or town) (State or country) ..... Maryland

PARENTS

10 NAME OF FATHER Neil Roy

11 BIRTHPLACE OF FATHER (city or town) (State or country) ..... Va

12 MAIDEN NAME OF MOTHER Beathane Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ..... Va

14 Informant (Address) Res'd JOHNS HOPKINS HOSPITAL.

15 Filed JUN 13 1924 ROBERT M. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1924 to June 12, 1924

that I last saw him alive on June 12, 1924

and that death occurred, on the date stated above, at 7 05 A.m.

The CAUSE OF DEATH* was as follows:

Acute Secondary Pneumonia (measles)

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R Bagg M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL June 14 1924

20 UNDERTAKER Edward Bryon — ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 lbs.

D 87791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-002

D 87791

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 234 Altamont St. 3 WARD)

2-FULL NAME Madgalini Dilorenzo

(a) RESIDENCE. No. 234 Altamont St. ST., 3 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. 13 mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	W Ital	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Sept 26 1923

7 AGE	Years	Months	Days
	1	23	18

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles Dilorenzo

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Athena Frankettaja

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Catherine Dilorenzo
(Address) 238 S. Altamont

15 JUN 13 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 12, 1924, that I last saw h. alive on June 12, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis
Acute Meningitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Croup

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jos. L. Valentine Jr. M. D.

June 13 1924 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 14 1924
20 UNDERTAKER	ADDRESS
Wendell Coppuck Son	37 Stirling

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

D 87792

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-003 ✓ D 87792

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Calvert & Saratoga ST., S 11 WARD)

2-FULL NAME James Stewart Clinton

(a) RESIDENCE No. 1027 Cathedral ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 5/16/24

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Stuart S. Clinton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri

12 MAIDEN NAME OF MOTHER Barbara Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address) Hospital Records

15 Filed JUN 13 1924 RUBEN R. KRAUTER Assistant Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 1924, to 6/12, 1924, that I last saw h[illegible] alive on 6/12, 1924 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Pyloric Stenosis – Mal-nutrition

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1/2 hour.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? Yes Date of 6/12/24

Was there an autopsy? No

What test confirmed diagnosis? Ovation

(Signed) L. W. Gallery, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/13/24
UNDERTAKER Geo. A. Farley	ADDRESS Fulton & Laytha

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D 87793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 76 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dawson

(a) RESIDENCE. No. Bay View Asylum St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 2440

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records

(Address)

JUN 3 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-10, 1924, to 6-11, 1924

that I last saw him alive on 6-11, 1924

and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Hypertension
Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sob.

(Signed) Claude B. Hoar, M. D.

6-11, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 13 1924
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1631 N. Fremont St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87794

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3910 Belle Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Oliver W Henderson

(a) Residence No. 3910 Belle Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah F.

6-DATE OF BIRTH (month, day and year) Feb 6 1841

7-AGE 5/ yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe Maker

(b) General nature of Industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Eastern Shore Md

PARENTS.

10-NAME OF FATHER, John Henderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Eliza Howe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Dolan E Henderson

(Address) 3910 Belle Ave

15- Filed JUN 13 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12-24

17- I HEREBY CERTIFY, That I attended deceased from —, 19—, to June 12, 19 24, that I last saw him alive on June 12, 19 24, and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation with dropsy (Duration) Same yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) M Bernard Ford, M. D.

June 12, 1924 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 15, 19 24

20-UNDERTAKER	ADDRESS
H Cook	502 E. Fayette

Spec.—1-10-21—M&T—1500 Blks.

D 87795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 001 ✓ D 87795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 W. Belvedere Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Landrigan

(a) RESIDENCE No. 312 W Belvedere Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Landrigan

6 DATE OF BIRTH (month, day, and year) June 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Worden

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Catherine Clee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elsie M. Nettleship

(Address) 312 Belvedere Ave

15 JUN 13 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8 1924 to June 12 1924

that I last saw her alive on June 11 1924

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Primary)

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Dilated Heart

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles J. Nick, M. D.

, 19 (Address) 2 W Belvedere Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: June 14 1924

20 UNDERTAKER: Murdock — ADDRESS: 1026 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87796

CERTIFICATE OF DEATH.

100-B 87796

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 161 Montebello Ter St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Frederick Tontrup

(a) Residence No. 161 Montebello Ter, St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 53 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: late Mary Tontrup

6-DATE OF BIRTH (month, day and year) 12/5/43

7-AGE. 80 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Tontrup

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ger

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ger

14- (Informant) Mrs Dora Haafner

(Address) 161 Montebello Ter.

15- JUN 1 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6/11/24

17- I HEREBY CERTIFY, That I attended deceased from June 8th, 1924 to June 11th, 1924.

That I last saw him alive on June 11th, 1924

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal observation.

(Signed) Wm Conrad Bode, M. D

, 19 (Address) 1900 Maryland Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: 6/14, 1924

20-UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87797

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 D 87797

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 417 Roland Ave., St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Bertha A. Wegner

(a) Residence No. 417 Roland Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 53 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced. HUSBAND of (or) WIFE of Ralph J. Wegner

6-DATE OF BIRTH (month, day and year) Oct 30/67

7-AGE. 56 yrs. 7 mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Marietta Ohio

PARENTS.

10-NAME OF FATHER. Henry F. Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ger

12-MAIDEN NAME OF MOTHER. Martha E.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ger.

14-

(Informant). Ralph J. Wegner

(Address) 417 Roland Ave

JUN 1 3 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/11/24

17- I HEREBY CERTIFY, That I attended deceased from May 3, 1924 to June 11 1924

that I last saw h.er alive on 6/11 1924

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Breast

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Metastasis to R. Lung

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 14 yrs. Previous

Was there an autopsy? Yes.

What test confirmed diagnosis?.....

(Signed) Howard Kelly M. D.

6/12 1924 (Address) 20 Chas

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge

DATE OF BURIAL. 6/14 1924

20-UNDERTAKER. Philip Henry

ADDRESS 2016 Orleans

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87798

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87798

STILL BIRTH.

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hosp. 4 23 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Charles Hardman

(a) RESIDENCE NO. X ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred X yrs. X mos. X ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	X

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
X40 about	X	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work X

(b) General nature of Industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) X

PARENTS

10 NAME OF FATHER X

11 BIRTHPLACE OF FATHER (city or town) X (State or country)

12 MAIDEN NAME OF MOTHER X

13 BIRTHPLACE OF MOTHER (city or town) X (State or country)

14 Informant University Hospital (Address)

JUN 1 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

1313

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 11, 1924, that I last saw him alive on June 11, 1924, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Epidemic encephalitis.

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) R. J. Taylor M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19 JUN 13 1924

20 UNDERTAKER

ADDRESS

Cal 2650.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

body at Mercy Hospital Morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

87792

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., ... WARD)

2-FULL NAME Chas Hardman

(a) RESIDENCE NO Dont Know ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 50

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50 about			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Hosp
(Address)

15 Filed ....., 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 192

17 I HEREBY CERTIFY, That I took charge of remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, ... find that said deceased came to his de... (autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Encephalitis

(duration) ..... yrs. a few da... mos. .....

CONTRIBUTORY Dont Know
(Secondary)

(duration) ..... yrs. ..... mos. .....

(Signed) J. H. Bloomfield, M.
(Coroner.)

6/17, 192 4 (Address) 1177 W Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos.,

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

Spec. 1-19-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87799

CERTIFICATE OF DEATH.

D 87799

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 1 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Helen Silly.

(a) RESIDENCE NO. Cas bury, W. Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced (or) WIFE of: Dr. Fred Silly.

6 DATE OF BIRTH (month, day, and year): June 10 1891

7 AGE: Years 33 Months — Days 2 days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Monroe County West Virginia

PARENTS

10 NAME OF FATHER: Wm P. Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Monroe Co. W. Va.

12 MAIDEN NAME OF MOTHER: Rebecca Early

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Monroe Co. W. Va.

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL.

JUN 13 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1924. to June - 12, 1924.

that I last saw her alive on June - 12, 1924.

and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Post-operative lobar pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Ovarian Abscess right. Appendicitis infected & chronic

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of June-9-'24

Was there an autopsy? Not.

What test confirmed diagnosis? Physical signs

(Signed) Henry J. Boerner, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Concrete W Va — DATE OF BURIAL: June 13, 24

20 UNDERTAKER: Forsythe Sons — ADDRESS: 221 Busy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87800 | 61-001 | D 87800

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3230 Fairmount St.: No. 76 WARD) REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant son of Charles + Nora Hall

(a) RESIDENCE. No. 3230 Fairmount Av. ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Charles Hall

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Nora Bailey

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant .....
(Address) .....

15 Filed JUN 13 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June 12 19.24, to June 12 19.24, that I last saw h...alive on June 12 19.24, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth of seven months

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

..... 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.).

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 13 1924

20 UNDERTAKER Lilly + Zeiler ADDRESS 403 S. Wolfe St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87801 ✓ D 87801

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No. 1422 W. Pratt St., 19 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Feely

(a) Residence No. 1422 W Pratt St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5-5 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) 4-14-1855

7-AGE, 69 yrs. 1 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Keenah (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Cornelius Feely

11-BIRTHPLACE OF FATHER (city or town) Keenah (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Nancy Short

13-BIRTHPLACE OF MOTHER (city or town) Keenah (State or Country), Ireland

14- (Informant) Margaret B. Whelan

(Address) 1422 W Pratt St

15- Filed JUN 13 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to June 12, 1924, that I last saw h[illegible] alive on June 11, 1924, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

6/13, 1924 (Address) 108 N Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, June 14, 1924

20-UNDERTAKER, Wm. J. Hartwell ADDRESS 1536 W. Baltimore St.

UN 13 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—3000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87802

CERTIFICATE OF DEATH.

74 D 87802

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 W Dolphin ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alva Linthicum

(Residence in Baltimore: No. 315 W Dolphin St.; 12 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. August 27, 1858 (Month) (Day) (Year)

7-AGE. 65 yrs. 9 mos. 15 da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer). Engineer

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Ohio

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Linthicum

(Address) 315 W. Dolphin

15-

Filed JUN 13 1924 Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 11 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from JUN 8 1924 191, to JUN 10 1924 191, that I saw him alive on JUN 10 1924 191, and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) X yrs. X mos. 3 da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 10 yrs. X mos. X da.

(Signed) O H Burke M. D.

JUN 12, 1924. (Address) 928 E North Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem. DATE OF BURIAL, 6/13, 1924

20-UNDERTAKER Geo J Ruth ADDRESS 1735 Hanford Ave

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 1 31924

Cor.—1-12-23—M&T—100 Blks.

Charles H. Ball

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87803

CERTIFICATE OF DEATH.

1 88 D 87803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 4 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Ball-

(a) RESIDENCE—NO 1232 Good Hope Rd Wash-DC ST., WARD Wash. D. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town) Dont Know
(State or country)

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hospital Record Mercy Hospital
(Address)

JUN 3 1924

Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:* Accident

Fracture of Skull

(duration) hrs. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo Edward Rodier, M. D.
(Coroner)

6/3/24 192 (Address) 1426 Fenay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D C

DATE OF BURIAL June 16 1924

20 UNDERTAKER John Wellington

ADDRESS 2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87804

CERTIFICATE OF DEATH.

D 87804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 159 Colvin ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Bouldin

(a) RESIDENCE NO. 159 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Bouldin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Ella Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Estella Bouldin (sister) (Address) 159 Colvin st

15 JUN 14 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 12, 1924, that I last saw her alive on June 11, 1924, and that death occurred, on the date stated above, at 3.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute dilitation (Cardiac).
due to Acute Gastritis & Convulsions

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Indiscretion in diet and Auto intoxication

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical and history

(Signed) Physician attached M. D.

, 19 (Address) Henry Rutherford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashurst Cem.	June 14 1924
20 UNDERTAKER	ADDRESS
Furs J. G. Locks	1302 Jefferson

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87805

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Pennington Bond

(a) RESIDENCE NO. 1519 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of XXXX

6 DATE OF BIRTH (month, day, and year) June 10/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work XXXX
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mamie Pennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant William Bond
(Address) 1519 Argy

15 Filed JUN 14 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/24 192

17 I HEREBY CERTIEY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary & Meningeal Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. H. Carter (Coroner.), M. D.

June 14, 192 4 (Address) 508 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	June 14 192 4
20 UNDERTAKER Mrs J. G. Locks	ADDRESS 1302 Jefferson 21.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 87806

D 87806

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4318 E Lombard ST., No WARD)

2-FULL NAME Baby Hecker.

(a) RESIDENCE NO 4318 E Lombard ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 4-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Elmer E. Hecker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Marie Oburg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Elmer E. Hecker
(Address) 4318 E. Lombard St

15 FILED JUN 14 1924 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interval Hernia.

(duration) 5 yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Allen Rhodes, M. D.
(Coroner.)

6/14/24 (Address) 423 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	June 14th 192 4.
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 N Wolfe St.

GE should be stated EXACTLY. PHYSICIANS sho state
at it may be properly classified. Exact statement of CO
s on back of certificate.

nation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Cor.—1-12-23—M&T—100 Bks.

D 87807

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-D 87807

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Hynson

(a) RESIDENCE No 1427 McElderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 18 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 25/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Leroy Hynson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Effie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Effie Hynson
(Address): ~~1427 McElderry~~

15 Filed JUN 14 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Primary Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. L. Baer, M. D. (Coroner.)

June 14/24 (Address) 508 E. north Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ostbury Cemetery	June 14 1924
20 UNDERTAKER	ADDRESS
Milton Davis	915 N Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87808

CERTIFICATE OF DEATH.

101 001 D 87808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Dukeland St., 15 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Richard Spicknall

(a) RESIDENCE No. 2107 Dukeland St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 11 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 26 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas W Spicknall

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna E Metzger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr T. W. Spicknall
(Address) 2107 Dukeland

15 Jun 14 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17 I HEREBY CERTIFY, That I attended deceased from June. 1, 1924, to Jun 12, 1924.
that I last saw him alive on Jun. 12, 1924,
and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Toxemia & Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

What test confirmed diagnosis? .....

(Signed) T. H. Allen M. D.

(Address) 2737 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 14 1924

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D 87809

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp ST. Hosp WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James G. Corkran

(a) RESIDENCE NO. 1224 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	white	W. Sinai Hosp

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche E. Corkran

6 DATE OF BIRTH (month, day, and year) July 6-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) in Navy 129

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Corkran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Corkran (daughter) (Address) 1224 Battery Ave

15 Filed JUN 14 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1924

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to June 13, 1924

that I last saw him alive on June 13, 1924

and that death occurred, on the date stated above, at 8 00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of May 31/24

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo A McComas, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	6/16 1924
20 UNDERTAKER	ADDRESS
S. Fred McCully	130 E. Fort

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 37810 (3) 1723

3 D 37810

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 3 WARD)

2-FULL NAME Charles Williams

(a) RESIDENCE No. 428 S. Caroline St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year) July 12 1923

7 AGE — Years | 11 Months | 1 Days | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Rice Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Rena Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant Reads (Address) JOHNS HOPKINS HOSPITAL

15 JUN 14 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 13, 1924.

that I last saw her alive on June 13, 1924.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

(Tuberculous Meningitis)

Generalized Miliary Tuberculosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? ~~Sp~~ Lumbar Puncture

(Signed) Casper Jones, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury cemetery

DATE OF BURIAL: June 14 1924

20 UNDERTAKER: Edward Bryon

ADDRESS 1631 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87811

CERTIFICATE OF DEATH.

12 D 87811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3210 Fait Ave ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Omptedа

(a) RESIDENCE NO. 3210 Fait ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Omptedа

6 DATE OF BIRTH (month, day, and year) Feb. 23 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)

14 Informant Mrs. Agnus Hugel

(Address) 3210 Fait Ave

15- Filed JUN 14 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924

17

I HEREBY CERTIFY, That I attended deceased from 17 May , 1924, to 12 June , 1924,

that I last saw h alive on 12 June , 1924,

and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

a Chronic Endocarditis

and

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Evidence of Arterial Heal Pressure

(Signed) D. H. Mook, M. D.

, 19 (Address) 301 S Edmond Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL June 16 1924

20 UNDERTAKER Zukler & Zukler

ADDRESS 1739 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87812

CERTIFICATE OF DEATH

D 87812

161-06

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1753 Mulliken ST., 6 WARD)

2-FULL NAME Baby Burgess (~~Stillborn~~)

(a) RESIDENCE No. 1753 Mulliken So ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 12/1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER Isaac Burgess

11 BIRTHPLACE OF FATHER (city or town) North Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Mary Liston

13 BIRTHPLACE OF MOTHER (city or town) North Carol.
(State or country)

14 Informant Mary Burgess
(Address) 1753 Mulliken

15 Filed ..... 19 ..... Robert F. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/ 1924

17

I HEREBY CERTIFY, That I attended deceased from June 12/ 1924, to June 13 1924, that I last saw her alive on July 12/ 1924, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Postpartum Delirium
5 days

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Richard L Swindell, M. D.

, 19 (Address) 1814 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND.

20 UNDERTAKER Commissioner Health. ADDRESS

JUN 14 1924

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87813

CERTIFICATE OF DEATH

D 87813

1-PLACE OF DEATH (Permanent Dwelling, St Agnes Hosp) REGISTERED NO.

CITY OF BALTIMORE: (No. 522 Lewis ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Adams

(a) RESIDENCE NO 1740 Rayser ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) unknown
(State or country) South Carolina

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Police Dept.
(Address)

15 FILED JUN 14 1924, 192 Robert F. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Homicide - Pistol shot through brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. H. Feller, M. D.
(Coroner.)
, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	JUN 14 1924
20 UNDERTAKER [redacted] for Health.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 14 1924

THE MONUMENTAL PRINTING CO. 1545

Cor.—1-12-23—M&T—100 Bks.

D 87814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87814

CERTIFICATE OF DEATH.

198

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mersety Hospital ST., 77 WARD)

2-FULL NAME Walter Frazier

(a) RESIDENCE NO. 43 Wayne Al ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colr	Dont Know

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Dont Know				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Georgia Rayner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Retella Perkins
(Address) 118 Landing St

15 Filed JUN 4 1924 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 10 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy ~~or inquest~~) thereon and from the evidence obtained by said ..... Inquest, autopsy ~~or inquest~~) find that said deceased came to ~~h~~er death on the day stated above.

The CAUSE OF DEATH* was as follows:
Stab Wound in Chest — [illegible]

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cut by Dewy Jones

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Gemel, M. D.
(Coroner.)

6-14, 192 (Address) 107 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL June 14 1924

20 UNDERTAKER S. S. Brown & Son — ADDRESS 108 W Mont'g

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87815

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

City of BALTIMORE: (No. 1920 Linden Ave St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph A. Seligman

(a) Residence No..... 1920 Linden Ave St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie H. Seligman

6-DATE OF BIRTH (month, day and year) July 20th 1866

7-AGE. 57 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Physician

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Abraham Seligman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Kate Blondheim

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Balto Md

14- (Informant)..... Kate Seligman

(Address)..... 1920 Linden a

15- Filed ..... 19.. Robert P. Harrison, Registrar.

JUN 14 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 13/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 19th ....., 19 24, to Jun 13th ....., 19 24,

that I last saw h. alive on Jun 13th ....., 19 24,

and that death occurred, on the date stated above, at 4 00 ....m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ant. Scalenus

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Virginia Peters (Mother)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) A. B. Gamble, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Hebrew

DATE OF BURIAL. June 15, 1924

20-UNDERTAKER. Harold Sondheim

ADDRESS 118 N. Fw Royal Av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87816 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87816

CERTIFICATE OF DEATH 38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospitals ST., 6 WARD)

2-FULL NAME Walter Bishop

(a) RESIDENCE NO. 419 N. Carolina ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'H'D

(c) Name of employer

9 BIRTHPLACE (city or town) Snow Hill, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-21, 1924 to 6-13, 1924

that I last saw him alive on 6-12, 1924,

and that death occurred, on the date stated above, at 5.00 p. m.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis
Aortic Insufficiency
Myocardial Insufficiency

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Grace, M. D.

6-13 1924 (Address) Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem'y.	6/16/24
20 UNDERTAKER	ADDRESS
Eden A. Holland	1631 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87817 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87817

CERTIFICATE OF DEATH.

X 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Williams

(a) RESIDENCE NO. 701 J. St. Sparrows Pt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Provident Hospital (Address)

15 Filed JUN 15 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14- 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-11- 1924 to 6-14- 1924

that I last saw h. in alive on 6-13- 1924

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

From history

(duration) yrs. 7 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 17 Dn. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stephens S. Carolina	June 16 1924
20 UNDERTAKER Virginia Mfg Co.	ADDRESS
John F. Denny	715 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 87818

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Riverside ave. ST. 24 WARD)

2-FULL NAME Mary E. McKay

(a) RESIDENCE. NO. 1219 Riverside Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas E McKay

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Claude McKay

(Address) 1219 Riverside

15 Filed JUN 15 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to June 11, 1924

that I last saw h[illegible] alive on June 11, 1924

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows: Rheumatic Fever, Aortic Regurgitation, endocarditis, auricular fibrillation, Chronic nephritis.

(duration) four years. yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart. Congestion of lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical signs.

(Signed) J. Edward Norris, M. D.

6/14, 1924 (Address) 107 E. west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ridge Md Mary Co. Md	6/16/24
20 UNDERTAKER	ADDRESS
J J Foley & Sons	1318 Eutaw

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87819

CERTIFICATE OF DEATH

D 87819

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Thomas

(a) RESIDENCE NO. 1039 W. Calvert St. ST., McDonald Md. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	B	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Thomas

6 DATE OF BIRTH (month, day, and year) Dec. 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tyler & Bailey

9 BIRTHPLACE (city or town) (State or country) Buckingham Co Va.

PARENTS

10 NAME OF FATHER C. H. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Agee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Miller (Sister)

(Address) Calvert & Chase.

JUN 15 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924.

17 I HEREBY CERTIFY, That I attended deceased from June, 1924, to June 14, 1924.

that I last saw her alive on June 14, 1924,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis & Abscess

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 13/24

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Buckingham Va. Via Tams P.R.	6/15/24
20 UNDERTAKER Chas. Alexander	ADDRESS 1456 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87820

CERTIFICATE OF DEATH.

14001

D 87820

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 So. Carey ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred B. Moore

(a) RESIDENCE NO. 31 So. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Moore

6 DATE OF BIRTH (month, day, and year) Feb 16 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	33	3	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman of Painters
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Geo Tolectric Co

9 BIRTHPLACE (city or town) (State or country) No. Carolina

PARENTS

10 NAME OF FATHER Robt E. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Whitson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C —

14 Informant Elizabeth Moore
(Address) 31 So. Carey St —

15 JUN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1½ hours (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) High blood pressure

(duration) ... yrs. ... mos. ... ds.

(Signed) Chas. B. Norton, M. D.
(Coroner.)

June 13 1924 (Address) Curtis Bay Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 16 1924
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87821

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D 87821

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2503 W. Fayette St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Virginia Hogan

(a) Residence No. 2503 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Osborne L. Hogan

6-DATE OF BIRTH (month, day and year): May 21, 1896

7-AGE: 28 yrs. - mos. 23 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore

(State or Country): Maryland

PARENTS.

10-NAME OF FATHER: John T. Neary

11-BIRTHPLACE OF FATHER (city or town): Prince George County

(State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Sarah E. Wharry

13-BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or Country): Maryland

14- (Informant): Osborne L. Hogan

(Address): 2503 W. Fayette Street

15- Filed JUN 5 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from 6/3/24, 19..., to 6/13/24, 19...

that I last saw her alive on 6/13/24, 19...,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Renal

(Signed) Bernard Feng, M. D.

6-14-1924 (Address) 910 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL, June 17, 1924

20-UNDERTAKER: Joseph B. Cook ADDRESS 1003 N. Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87822

CERTIFICATE OF DEATH.

90 D 87822

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2722 N. Mosher St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Anna Knecht

(a) Residence No. 2722 N. Mosher St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of the late John A. Knecht

6-DATE OF BIRTH (month, day and year) Dec. 31 1851

7-AGE. 72 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country), ... Md

PARENTS.

10-NAME OF FATHER, Henry Kaiser

11-BIRTHPLACE OF FATHER (city or town)..... Germany
(State or Country).....

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... Not Known
(State or Country).....

14- (Informant) Mr. Francis F. Knecht

(Address) 2722 N. Mosher St.

15-

JUN 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 14 1924

17- I HEREBY CERTIFY, That I attended deceased from April – 1918 to June 14 1924

that I last saw h.. alive on June 14 1924

and that death occurred, on the date stated above, at 7.20 A. m.

The CAUSE OF DEATH* was as follows:

Sudden death due to acute Dilatation of the heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart

(Duration) 6 mo. 4 days

18-Where was disease contracted if not at place of death? Immaterial.

Did an operation precede death? No Date of –

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) John Zierler M. D.

6/15 1924 (Address) 1123 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cemetery	June 16, 1924
20-UNDERTAKER.	**ADDRESS**
Henry Horch Son	1301 E Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 87823

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2794½ Alameda St., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia V Wills

(a) RESIDENCE NO. 2794½ Alameda St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ (or) WIFE of William T Wills

6 DATE OF BIRTH (month, day, and year) June 23 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country) —

14 Informant Mrs Alma Johnson

(Address) 2794½ Alameda

15 Filed JUN 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Distr.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 —, 1924, to June 13, 1924,

that I last saw her alive on June 12 —, 1924,

and that death occurred, on the date stated above, at 9 45 P.M.

The CAUSE OF DEATH* was as follows:

Con & Ascending Paralysis

(duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Asthma

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. N. Rader M.D.

, 19 (Address) 1904 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL June 16 1924

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87824

D 87824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 Edmondson Ave. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Clark

(a) RESIDENCE No. 832 Edmondson Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20th 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) Gallery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Samuel Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Emily Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Edward A. Clark

(Address) 837 Edmondson Ave.

15 Filed JUN 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13. 1924

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1924.

that I last saw him alive on June 12th, 1924.

and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Hemorrhage

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

6/13, 1924 (Address) 924 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 6/16 1924

20 UNDERTAKER David Easton

ADDRESS 916 Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87825 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87825

CERTIFICATE OF DEATH.

43 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1101 Myrtle St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Chester

(a) Residence No. 1101 Myrtle St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	col	Widower

5a-If married, widowed, or divorced HUSBAND of (~~or~~) WIFE of Fannie Chester

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE	If LESS than 1 day,
66 yrs — mos — ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) General

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore City
(State or Country),

PARENTS.

10-NAME OF FATHER, Jeremiah Chester

11-BIRTHPLACE OF FATHER (city or town) Barbados
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country),

14- (Informant) Sadie Chester

(Address) 1101 Myrtle Ave

15- JUN 15 1924 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/12/24

17- I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1924, to June 12, 1924,

That I last saw h.. alive on June 12, 1924,

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lower Maxillary

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Hank E. Wagner, M. D.

6/13, 1924 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel Cem.	6-16, 1924
20-UNDERTAKER,	ADDRESS
Daniel Easton	716 [illegible]

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information instructions on back of certificates. See ed. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87826 ✓ D 87826

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Elm Place ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Gant

(a) RESIDENCE NO. 921 Elm Place ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Harry Lee Gant

6 DATE OF BIRTH (month, day, and year) Oct 13. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Atlantic City N J

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Harry Lee Gant
(Address) 921 Elm Place

15 Filed JUN 15 1924 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13. 1924

17 I HEREBY CERTIFY, That I attended deceased from July 15th, 1924 to June 13 1924

that I last saw her alive on June 13, 1924

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Coal Tuberculosis

(duration) 11 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1737 N Caroline

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Thos. M. D.

6/13, 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W W Auburn Ave — DATE OF BURIAL 6-16-24

20 UNDERTAKER Daniel Easton — ADDRESS 916 Pine

U. S. WHITE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87827 ✓ D 87827

D 87827

CERTIFICATE OF DEATH.

71-001

1-PLACE OF DEATH St. Elizabeth's Home - Chesnut Hill Ave 9 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Nathaniel Jenkins

(a) Residence No..... St. Elizabeth's Home Chesnut Hill ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, negroe

5-Single, Married, Widowed, or Divorced, (Write the word.) ~~M~~ S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 3/23

7-AGE, ... yrs. 8 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Howard Berry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Washington D.C

12-MAIDEN NAME OF MOTHER, Ruth Jenkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) St. Elizabeth Home.

(Address).....

15- Filed JUN 15 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/13/24

17- I HEREBY CERTIFY, That I attended deceased from May 1924 to June 13 1924

that I last saw him alive on June 13 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Simple Meningitis

.....(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY.....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Grant J. Ayd M. D.

June 14, 1924 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
MT Auburn Cem	6-16-24
20-UNDERTAKER, Smith Corbus	ADDRESS 916 Cathedral

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lbs.

D 87828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 87828

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital WARD)

2-FULL NAME Louise Jenifer

(a) RESIDENCE No. 1323 Lemmon st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Harry Jenifer

6 DATE OF BIRTH (month, day, and year) Nov 18-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Louis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lizzie Johnson

(Address) 1323 Lemon st

15 JUN 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13/1924

17

I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 13, 1924.

that I last saw her alive on June 13, 1924

and that death occurred, on the date stated above, at 5.50 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

Probably about 10 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) acute nephritis, syphilis operative shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1323 Lemmon st

Did an operation precede death? yes Date of 6/13/24

Was there an autopsy?

What test confirmed diagnosis? Laparotomy

(Signed) Douglass A. Haddock, M. D.

, 19 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-17 1924
20 UNDERTAKER David Carton.	ADDRESS 916 Ca ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87829

CERTIFICATE OF DEATH.

16-002 D 87829

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 801 S. Sixth ST., No. WARD)

2-FULL NAME Thelma F. Hodges

(a) RESIDENCE NO. 801 S. Sixth ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 2-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	1	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chas. Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portsmouth, Va.

12 MAIDEN NAME OF MOTHER Anna Herg.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Chas. Hodges

(Address) 801 S. Sixth St.

15 Filed JUN 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1924, to June 15, 1924,

that I last saw he alive on June 14, 1924,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery "Acute Bacillary"

(duration) yrs. mos. 10 ds.;

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Litton M. D.

6/15, 1924 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	June 16 1924
20 UNDERTAKER	ADDRESS
Zirkelen + Zirkelen	1739 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87830

11-002

D 87830

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 15 WARD)

2-FULL NAME David Mervis

(a) RESIDENCE NO. 3722 Reisterstown ST. Rd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? 3 yrs. 5 mos. 15 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/27/21

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Samuel Mervis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Sanberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky

14 Informant Samuel Sandberg

(Address) 3722 Reisterstown Rd

15

JUN 15 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-10, 1924, to 6-10, 1924, that I last saw him alive on 6-15, 1924, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Influenza Meningitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Lumbar puncture

What test confirmed diagnosis?

(Signed) Irene A. Weber M. D.

6/15 1924 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Blvd

DATE OF BURIAL 6/15 1924

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 112 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87831

CERTIFICATE OF DEATH.

51 D 87831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Dolphin ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl A. Moody

(a) RESIDENCE NO. 539 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5th 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Charles O. Moody

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Carrie C. Bell

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Carrie O. Moody

(Address) 539 Dolphin st.

15 JUN 15 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1924

17

I HEREBY CERTIFY, That I attended deceased from June 8th, 1924, to June 12, 1924,

that I last saw him alive on June 12, 1924

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Inflammatory Rheumatism (duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry F. Brown, M. D.

6/13 1924 (Address) 150 Presstman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. R. Auburn Cem Co	June 15 1924
20 UNDERTAKER	ADDRESS
Emil J. Hemsley	Biddle

Spec.—1-10-21—M&T—1800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87832

74-001 ✓

D 87832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 616 Sarah Ann

CITY OF BALTIMORE: (No. 616 Sarah Ann ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Rhodes Jr

(a) RESIDENCE NO. 616 Sarah Ann ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 43 yrs. 9 mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	~~Divorced~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	43	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Various

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER Wm Rhoades Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Mary Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Johns Rhodes

(Address) 2125 N McCulloh

15 Filed JUN 15 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12 1924

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1924, to June 12, 1924, that I last saw him alive on June 12, 1924, and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Coma

(duration) ... yrs. ... mos 1 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no.

What test confirmed diagnosis? —

(Signed) Gustav Goldman, M. D.

6/14, 1924 (Address) 616 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	6/15 1924
20 UNDERTAKER	ADDRESS 578 W Biddle
Samuel F Townley	

NAME—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87833 — 101 — D 87833

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 W. 24th St — ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Cecelia Harrison

(Residence in Baltimore: No. 427 W. 24th St — St.; 1 yrs., 11 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, June (Month) 19 (Day), 1924 (Year)

7-AGE, 5 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, William F. Harrison

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Bertha Duffy.

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Harrison

(Address) 427 W. 24th st.

JUN 5 1924

Filed....., 191... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 14th (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1924, to June 14 1924, that I saw her alive on June 14 1924, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration)....yrs....mos. 10 ds.

CONTRIBUTORY (Secondary)

..... (Duration)....yrs....mos....ds.

(Signed) Geo. R. N. Wells M. D.

....., 191... (Address) 1413 Edmondson Ave,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cath Cem	6/7, 1924
20-UNDERTAKER	**ADDRESS**
I. Frew McCully	130 E. Fort

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Bishop York Road & Sheridan Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87834

CERTIFICATE OF DEATH.

D 87834

1-PLACE OF DEATH

City of BALTIMORE: (No. 3702 Old York Road St., ... Ward) 9

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Milburn

(a) Residence No. 3402 Old York Road St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine L

6-DATE OF BIRTH (month, day and year) May 9 1862

7-AGE, 62 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Md Metal Co

(c) Name of employer Co

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Milburn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary Fairbanks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) Mrs C. Chisnell

(Address) 570 Brandeis Terrace

JUN 15 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 14 24

17- I HEREBY CERTIFY, That I attended deceased from Feb 2 1924 to June 14 1924

that I last saw him alive on June 14 1924,

and that death occurred, on the date stated above, at 10A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Angina Pectoris

Chron Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) G. W. Bishop M. D

June 14 1924 (Address) 501 Sheridan Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL, June 17 1924

20-UNDERTAKER, Wm Cook ADDRESS 502 E Ave

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See Exact statement of OCCUPATION is very important, should be carefully supplied. AGE should be stated instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87835

CERTIFICATE OF DEATH.

118-002 D 87835

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2 Southern Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Veronica Francis Merz

(a) Residence No. 2 Southern Ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	W.	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad G. Merz

6-DATE OF BIRTH (month, day and year) March 6, 1850

7-AGE	If LESS than 1 day,
74 yrs. 3 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home D 1 0

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS

10-NAME OF FATHER Casper Amrhein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catona Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Elizabeth Kelly

(Address) 2423 Fleetwood St

JUN 15 1924 ROBERT N. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 10th 24 to June 13th 24

that I last saw h... alive on June 13th 24

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) W. H. Long M. D.

June 14th 24 (Address) 801 Cathedral

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park	June 17, 1924
20-UNDERTAKER	ADDRESS
Wm Cook	502 E Lexington

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87836

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-002 D 87836

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital No. 2 St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Adam B. Wiest

(Residence in Baltimore: No. 427 S. 39 St. St. Yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Husband

6-DATE OF BIRTH. March 11 (Month) (Day) 1884 (Year)

7-AGE. 39 yrs. 3 mos. 1 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electrics

9-BIRTHPLACE, (State or Country). Balt City. 029

PARENTS.

10-NAME OF FATHER. Jacob Wiest

11-BIRTHPLACE OF FATHER, (State or Country). Balt City

12-MAIDEN NAME OF MOTHER. Elizabet Engelbrecht

13-BIRTHPLACE OF MOTHER. (State or Country). Balt City.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph M Wiest

(Address) 701 N Collington Ave.

15- Filed JUN 5 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 12 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture & Knee & Crushed & Leg, Automobile & Street Car accident

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage from Brain

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) James M Fenton M. D. (Coroner.)

June 14, 1924. (Address) 700 E Chase St

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? Eastern Ave & Patapsco St

Former or usual residence 427 S 39 St

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel DATE OF BURIAL, June 15 1924

20-UNDERTAKER, William G. Schaffer ADDRESS 1816 Monument St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87837

CERTIFICATE OF DEATH.

D 87837 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Frank Sloka Celuska

(a) Residence No. 409 N. Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Marie Sloka Celuska

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day,
54 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Shoemaker

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 088

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Austria

PARENTS.

10-NAME OF FATHER, Thomas Sloka

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Austria

12-MAIDEN NAME OF MOTHER, Jan —

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Austria.

14- (Informant) Marie Sloka Celuska

(Address) 409 N. Bradford St.

JUNT 5 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-13-24

17- I HEREBY CERTIFY, That I attended deceased from June 10 1924 to June 13 1924

that I last saw him alive on June 13 1924

and that death occurred, on the date stated above, at 4-20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Oesophagus

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-13-24

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological findings

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Holy Cross	June 16 1924
20-UNDERTAKER,	ADDRESS
Frank Evers Son	1106 Eutaw St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87838

51 D 87838

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 825 N. Belnord Ave. WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Getzinger

(a) RESIDENCE NO. 825 N. Belnord Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct 3rd 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Chas A. Getzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City

12 MAIDEN NAME OF MOTHER Sadie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Chas. A. Getzinger (Address) 825 N. Belnord Ave

15 Filed JUN 5 1924 ROBERT N. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1924 to June 13 1924.

that I last saw h alive on June 13 1924

and that death occurred, on the date stated above, at 11 45 a m.

The CAUSE OF DEATH* was as follows:

acute Bronchitis — acute

Lobar Pneumonia

acute Endocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Stinchcomb, M. D.

6/13, 1924 (Address) 820 N Matt 1411

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	June 16 24
20 UNDERTAKER	ADDRESS
Geo M. Fink & Son	811 N Wolfe

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of c

DEATH CERTIFICATES AND BURIAL PERMITS. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87839

CERTIFICATE OF DEATH.

90 D 87839

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2638 Dulaney ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar A. Riemau

(a) RESIDENCE NO. 2638 Dulaney ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Rieman

6 DATE OF BIRTH (month, day, and year) Aug 26 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Spring Bed Maker

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Aug. Rieman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mathilda Schaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Catherine Rieman (Address) Bonnies Md.

15 Date JUN 15 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5 1924 to June 11 1924.

that I last saw him alive on June 11 1924.

and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Mitral Insufficiency.

(duration) ... mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Robert C. Nitsche, M. D.

6/12, 1924 (Address) 2151 Eutaw Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL June 16 1924

20 UNDERTAKER Geo. M. Frick & Son ADDRESS 811 N. Wolfe

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be p
TION is very important. See instructions on back of c
of certificates.

Spec.—A 10-21 M&T 1500 Bks.

17036 87840

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 161-001 ✓ D 87840

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Charles Weigand.

(a) RESIDENCE NO. Hagerstown Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 19 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	X	8	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H

(b) General nature of industry, business, or establishment in which employed (or employer) H

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md.

PARENTS

10 NAME OF FATHER Edward Weigand

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Spessard

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUNE 5 1924, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1924

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1924, to June 4, 1924,

that I last saw him alive on June 4, 1924,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity - Marasmus

Since Birth (duration) yrs. 8 mos 25 ds.

CONTRIBUTORY (Secondary) None -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of January 19, 1924

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thos W Cornwall, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown, Md. DATE OF BURIAL June 5 1924

20 UNDERTAKER Fact Service, 1439 E. Balto ADDRESS

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87841

CERTIFICATE OF DEATH.

140 D 87841

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument St & Rutland Ave ST.) (WARD)

2-FULL NAME Annie Frishkind

(a) RESIDENCE NO. 1000 Druid Hill Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Frishkind

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Kalin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Kurant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Baltimore

15 Filed JUN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/8, 1924, to 6/14, 1924.

that I last saw h[illegible] alive on 6/14 1924.

and that death occurred, on the date stated above, at 10:20 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Puerperal peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/13/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidore L. Jay, M. D.

6/14, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Jasmel	6/15 1924
20 UNDERTAKER Jack Levis	ADDRESS 1439 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87842

CERTIFICATE OF DEATH.

74 001

D 87842

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 202 S. Chester St.

CITY OF BALTIMORE: (No. 202 S. Chester ST., V WARD)

2-FULL NAME Minnie Tarr

(a) RESIDENCE No. 202 S. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas. A. Tarr

6 DATE OF BIRTH (month, day, and year) Oct 18 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H.W. 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Matthew Poncet

11 BIRTHPLACE OF FATHER (city or town) France
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Charles A Tarr
(Address) 202 S Chester St

15 JUN 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13/1924

17 I HEREBY CERTIFY, That I attended deceased from 6/13/1924, to 6/13/1924

that I last saw her alive on 6/13/1924, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Chr Diffg Nephritis

Hypertension

(duration) one hour yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard J Sexton, M. D.

6/14/1924 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 16 1924
20 UNDERTAKER	ADDRESS
Harry H Nutzke	153 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7-4-00 D 87843

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 531 N. Ellwood ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William G. Frankmiller

(a) Residence No. 531 N. Ellwood ave. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Margaret Harlow Miller

6-DATE OF BIRTH (month, day and year) Aug 24 1842

7-AGE. 81 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... City

(State or Country)..... dont know

PARENTS.

10-NAME OF FATHER, dont know

11-BIRTHPLACE OF FATHER (city or town)..... Germany

(State or Country).....

12-MAIDEN NAME OF MOTHER, dont know

13-BIRTHPLACE OF MOTHER (city or town)..... Germany

(State or Country).....

14- (Informant) Mrs. Thos. Eaton

(Address) 531 N. Ellwood ave.

15- FILED JUN 15 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/12/24

17- I HEREBY CERTIFY, That I attended deceased from 5-15 1924 to 6-12 1924

and last saw h[illegible] alive on 6-12 1924

and that death occurred, on the date stated above, at 9 5p m.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. France M. D.

6-14. 1924 (Address) 2939 McElderry

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. St. Paul Cemetery

DATE OF BURIAL. June 15, 1924

20-UNDERTAKER J. A. Moran

ADDRESS 830 E. Baltimore St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ec—12-23-21—F.B.R.S.—400 Bks.

D 87844 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87844

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 729 E Preston St., 10 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth B Morgan

(a) Residence No. 729 E. Preston St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Morgan

6-DATE OF BIRTH (month, day and year) Sept 24 1865

7-AGE, 59 yrs. 9 mos. ds.

If LESS than 1 day, hrs. or mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Scotland

PARENTS.

10-NAME OF FATHER Thos McWilliams

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Mary Gaffney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14-

(Informant) Chas Morgan

(Address) 729 E Preston St

JUN 5 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6/13/24

17- I HEREBY CERTIFY, That I attended deceased from May 9/24 19.. to 6/13 1924

that I last saw h.. alive on 6/13 1924

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

8

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr Bernard Cohen, M. D.

6/14, 1924 (Address) 914 E Fiddler St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Herbath Cathedral Ben	June 16, 1924
20-UNDERTAKER	ADDRESS
J. A. Moran	300 E Balto St.

Instructions on back of certificates.

plain terms, so that it may be properly classified.

and be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

D87845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D87845

CERTIFICATE OF DEATH.

146. D 87845

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 304 S Exeter St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Adele Diliello

(Residence in Baltimore: No. 304 S. Exeter St.; 20 yrs., ...mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-~~Single,~~ Married, ~~Widowed,~~ or ~~Divorced.~~ (~~Write the~~ word.) Married

6-DATE OF BIRTH. (Month) March (Day) 6 (Year) 1882

7-AGE. 42 yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Casper Loggi

11-BIRTHPLACE OF FATHER. (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Liliosa Sammartino

13-BIRTHPLACE OF MOTHER. (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Diliello

(Address) 304 S Exeter St

15-Filed JUN 15 1924 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 14 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

about 4 hrs. Contusions

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) James M. Kenney M. D.
(Coroner.)

June 14 1924 (Address) Post Chester

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, June 16 1924

20-UNDERTAKER, Wendell Appleton — ADDRESS 378 Inma

r.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87846

CERTIFICATE OF DEATH.

V 87846

90

D 87846

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Astor Court Apt

CITY OF BALTIMORE: (No. St. Paul + 25th ST., 12 WARD)

2-FULL NAME Mary Brockie

(a) RESIDENCE No St. Paul + 25th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Brockie

6 DATE OF BIRTH (month, day, and year) May 9, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Geo. Husband

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Aiken

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Edith L. Brockie
(Address) St Paul + 25th Sts.

15 Filed JUN 15 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. H. Monnaday M. D.
(Coroner.)

June 15 1924 (Address) 3632 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	June 16 1924
20 UNDERTAKER Wm Fickus & Sons	ADDRESS North St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87847

CERTIFICATE OF DEATH.

90 87847

D 87847

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No 808 Burgundy St. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jennie Lathe

(a) RESIDENCE. No. 808 Burgundy ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence E Lathe

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46 Years Old	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: William Higdon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Zenobia Peck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Mr Andrew L Miller

(Address) 808 Burgundy St

15 Filed JUN 15 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1924, to June 13, 1924, that I last saw her alive on June 13, 1924, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M. Dilcrett, M. D.

June 13, 1924 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	6/16 19 24
20 UNDERTAKER	ADDRESS
Wm J. Tschudy & Son	North Ave

NOTICE—THIS CERTIFICATE SHOULD BE FILLED OUT IN BLACK INK OR TYPEWRITTEN, AND WITHOUT ERASURES. ALL ITEMS SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87848

D 87848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph Hospital

REGISTERED NO. 10 1886

CITY OF BALTIMORE: (No.) 1041 Greenmount Ave ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Filmonia Grande

(a) RESIDENCE NO 1041 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
emale	white	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	c	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Frank Grande

11 BIRTHPLACE OF FATHER (city or town) Ttaly
(State or country)

12 MAIDEN NAME OF MOTHER Rose Delia

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Frank Grande
(Address) 1041 Greenmount Ave

15 JUN 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to he death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-Struck by auto-truck

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Race, M. D.
(Coroner.)

June 15/24 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents — DATE OF BURIAL June 16 1924

20 UNDERTAKER J. C. Wiedefeld — ADDRESS 914 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87849

CERTIFICATE OF DEATH.

1624 D 87849

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2607 Foster ave 1 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonina Poshnagny

(a) Residence No. 2607 Foster ave 1 St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 14 1924

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or 30 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md
(State or Country)

PARENTS:

10-NAME OF FATHER Wladyslow Poshnagny

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country)

12-MAIDEN NAME OF MOTHER Elenora Grafegnik

13-BIRTHPLACE OF MOTHER (city or town) Poland
(State or Country)

14-Informant Wladyslow Poshnagny

(Address) 2607 Foster ave

JUN 16 1924

ROBERT R. KRAUTER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 14 1924

17- I HEREBY CERTIFY, That I attended deceased from June 14 1924 to June 14 1924

that I last saw her alive on June 14 1924

and that death occurred, on the date stated above, at 3.16 a.m.

The CAUSE OF DEATH* was as follows:

Compression of Umbilical Chord during Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Sutton M D

6/14 1924 (Address) 315 S Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
G. W. Mayer Sons Cem	June 16 1924
20-UNDERTAKER.	ADDRESS
Stefan J Fralkowski	1008 Kenwood Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87850

CERTIFICATE OF DEATH.

124

D 87850

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721 N Edew St. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kendall Armstrong

(a) RESIDENCE NO. 721 N. Edew ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Mary E Armstrong

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Approx	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Mary Armstrong (wife)

(Address) 721 N Edew St

Filed JUN 16 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to June 13, 1924, that I last saw him alive on June 12, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) yrs. mos. 2d ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. G. [illegible] M. D.

6/14, 1924 (Address) 1419 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL June 16 1924

20 UNDERTAKER Mrs J. G. Locke

ADDRESS 1302 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8785 ✓ 90 D 8785

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen'l Hosp ST., 25 WARD)

2-FULL NAME Mrs. Catherine Kirby

(a) RESIDENCE NO. 815 Custer Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kirby

6 DATE OF BIRTH (month, day, and year) July 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER — Minister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Joseph Kirby

(Address) 20 Custis Ave Curtis Bay

Filed JUN 15 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-11-24, 19..., to 6-12, 1924, that I last saw her alive on 6-12, 1924, and that death occurred, on the date stated above, at 7 05 A m.

The CAUSE OF DEATH* was as follows:

Ch. Cholecystitis

Ch. Myocarditis

(duration) ? yrs. ? mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Jno A Young M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	June 16 1924
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1477 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25t—M&T—100 Blks.

D. 87852

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Gwynns Falls 1824

CITY OF BALTIMORE: (No. Beck's Run St., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert L. Falk.

(a) RESIDENCE NO. 1718 Poplar Grove St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1912.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jacob Falk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Oppenheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Isabella Falk
(Address) 1718 Poplar Grove St.

JUN 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

accidental drowning

Fell into Beck's Run

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy (Coroner.), M. D.

June 14, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	6/16/1924
20 UNDERTAKER	ADDRESS
David Sondheim	17-20 N. Gay St. Royal Cove

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87853

CERTIFICATE OF DEATH.

31 D 87853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2705 Garrison Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles. H. Shultz

(a) RESIDENCE NO. 2705 Garrison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Mollie. B. Shultz

6 DATE OF BIRTH (month, day, and year) April 20, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Vinegar

(b) General nature of Industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles. H. Shultz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Sophronia Sawns

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs Mollie B Schultz
(Address) 2705 Garrison Ave

15 JUN 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924

17

I HEREBY CERTIFY, That I attended deceased from May 4, 1924, to June 15, 1924, that I last saw him alive on June 15, 1924 and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum examination

(Signed) Samuel Volpan M. D.

, 19 (Address) 2705 ~~Garrison Ave~~ 2424 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 6/17 24

20 UNDERTAKER Graham F. Miller — ADDRESS 723 W Lafayette Ave

C. Carson. Stannard. Sucsm

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 87854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 87854

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4401 Walnut Ave St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lampen Cole

(Residence in Baltimore: No. 4401 Walnut Ave St.; yrs., 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow(er), or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. December (Month) 21 (Day) 1860 (Year)

7-AGE. 63 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Draughtsman
(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

9-BIRTHPLACE, (State or Country): Bristol-England.

PARENTS.

10-NAME OF FATHER. Henry H. Cole.

11-BIRTHPLACE OF FATHER, (State or Country). England.

12-MAIDEN NAME OF MOTHER. Sarah Sandy.

13-BIRTHPLACE OF MOTHER, (State or Country). England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Annie Cole (wife)

(Address) 4401 Walnut Ave

15-
JUN 16 1924
ROBERT R. KRAUTER,
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 13, (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 14 1924 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death 35 yrs. ? mos. ? ds. In the State 35 yrs. ? mos. ? ds.

Where was disease contracted, if not at place of death?

4401 Walnut Ave

Former or usual residence 4401 Walnut Ave

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	June 16 1924
20-UNDERTAKER. STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)	ADDRESS 108 W. NORTH AVE.

U. S. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Horace Bantum

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Jockson court ST.: V WARD)

1923 D 87855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Bantum

(a) RESIDENCE. No. 1435 Jockson court ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jobworker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm Bantum (son)
(Address) 253 N Eutaw

15 Filed JUN 16 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to June 14, 1924, that I last saw h alive on June 13, 1924 and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Gangrene foot, (duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ard Sclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Bantum M. D.

6-16-24 (Address) 2017 E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	June 16 1924

20 UNDERTAKER John W Henderson ADDRESS 1502 E Monument

Information should be carefully supplied. AGE should be stated EXACTLY. Every item of information is required. CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87856

CERTIFICATE OF DEATH.

129 D 87856

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1733 Druid Hill Ave ST., 14 WARD)

2-FULL NAME Miss Priscilla Wells

(a) RESIDENCE NO. 1733 Druid Hill St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE 73 Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Saml. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Newton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Laura Booth

(Address) 1733 E. Druid Hill Ave

15 JUN 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-2-24, 19..., to 6-14-24, 19...,

that I last saw h[illegible] alive on ", 19...,

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) senility, debility

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. M. Cayton M. D.

6/16/24 (Address) 1524 Eutaw Place,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem | DATE OF BURIAL June 16 1924

20 UNDERTAKER Sam'l W. Chase & Son | ADDRESS 1400 Madison

INFORMATION TO BE FURNISHED, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87857

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 87857

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 803 Fark Ave St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Powell

(a) Residence No. 803 Park Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F. Fem

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 77 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country), "

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- Jas Powell (Informant)

(Address) 803 Park Ave

15- JUN 16 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 13-24

17- I HEREBY CERTIFY, That I attended deceased from May 1, 19 24, to June 13, 19 24, that I last saw h alive on June 12, 19 24, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Following Cerebral Hem

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

June, 193 (Address) 837 N Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 16 19 24

20-UNDERTAKER, Sam'l H. Chase & Son

ADDRESS 400 N Fulton

Fill out carefully, supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87858
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

4 145 - 002

D 87858
Registered No.....

City of BALTIMORE: (If not in a hospital or institution, give residence.) Franklin Square Hosp. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Weinberg

(a) Residence No. 331 St Paul Place St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Nathan Weinberg

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 33 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER Louis Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Snyder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis
(Address) 1439 Eutaw St

JUN 16 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 15 1924

17- I HEREBY CERTIFY, That I attended deceased from June 14 1924 to June 15 1924

that I last saw h.er alive on June 15 1924

and that death occurred, on the date stated above, at 3.20 P.M.

The CAUSE OF DEATH* was as follows:

Chiled birth Instrument Delivery

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Post Partum Shock

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/15/24

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. S. Kobrin M. D.

6/15 1924 (Address) 1576 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Lefferts Mt Carmel — DATE OF BURIAL, June 16 1924

20-UNDERTAKER. Jack Lewis — ADDRESS 1439 E Eutaw

If not buried or cremated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87859

CERTIFICATE OF DEATH.

161-001

D 87859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 150 X Grace Court ST., 25 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Twardick (Illegitimate)

(a) RESIDENCE NO. 150 X Grace Court ST., 25 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 19, 192X

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Baltimore

10 NAME OF FATHER Joseph Twardick

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Twardick

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mother refused to give name
(Address) Curtis Bay Baltimore

JUN 16 1924

Registrar

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 192X

17 I HEREBY CERTIFY, That I attended deceased from June 15, 192X, to June 15, 192X,

that I last saw h— alive on June 15, 192X,

and that death occurred, on the date stated above, at 12.40 p. m.

The CAUSE OF DEATH* was as follows:

Suffocation due to premature birth of 7½ mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Leon L. Stokes, M. D.

(Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	JUNE 16 19 24
20 UNDERTAKER	ADDRESS
John F Denny	715 L. St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87860

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 87860

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal tuberculosis Hospital 3 St., ... Ward)

(If death occurred in a hospital or Institution, give its NAME Instead of street and number.)

2-FULL NAME James B. Hayes

(a) Residence No. 1415 eastern ave. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Separated

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1868

7-AGE.	If LESS than 1 day.
56 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Granite cutter

(b) General nature of industry, business, or establishment in which employed (or employer). 676

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country). Georgia

PARENTS.

10-NAME OF FATHER. John F. Hayes

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country) Georgia

12-MAIDEN NAME OF MOTHER. Jane Bohannon

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country) Georgia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 4 19 19 to June 15 1924

that I last saw him alive on June 15 1924

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 5 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally, M. D.

6-15-1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Trinity Cemetery	June 16, 1924
20-UNDERTAKER.	ADDRESS
Chas. G. Black	742 W. North ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 8786 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 8786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W Haviland

(a) RESIDENCE NO. Hazelwood Ave Raspburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work xx.x
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John W. Haviland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Virginia McManus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co.

14 Informant John W. Haviland
(Address) Haxelwood Ave

15 Filed ....192.... ROBERT R. KRAUTZ Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Bronchpneumonia

Autopsy Hopkins

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) P. H. Callen, M. D.
(Coroner.)

June 16, 192 (Address) 1- E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dach Cemetery	June 16 1924
20 UNDERTAKER Robt J Turner	ADDRESS 1742 N Bond

TION is very important. See instructions on back of certificate. ...be properly classified. Exact statement of OCCUPA- ...in plain terms, so that it may be

Spec.—1-10-21—M&T—1500 Blks.

D 87862

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87862

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Lemmon Ave ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Knopf

(a) RESIDENCE NO. 1045 Lemmon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Knopf

6 DATE OF BIRTH (month, day, and year) Oct 30 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Se

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna E Klaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma Lindauer

(Address) 1045 Lemmon Ave

15 Filed JUN 16 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1924

17

I HEREBY CERTIFY, That I attended deceased from June, 1924, to June 16, 1924

that I last saw h alive on June 13, 1924

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo L Schwab, M. D.

June 16, 1924 (Address) 2320 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	June 18 1924

20 UNDERTAKER George L. Schwab ADDRESS 1101 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87863

HEALTH DEPARTMENT—CITY OF BALTIMORE D 87863

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 S. Payson St., 20 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo E. Ritter

(a) Residence No. 430 S. Payson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 11 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Ritter

6-DATE OF BIRTH (month, day and year): June 28-1857

7-AGE, 66 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Meat Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): 413

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Frank L. Ritter

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto. Md

12-MAIDEN NAME OF MOTHER: Theresa Imhoff

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Jersey City

14-

(Informant) Mrs. Katherine Ritter

(Address) 430 S. Payson St.

15-F JUN 16 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 15, 1924.

That I last saw him alive on June 14, 1924,

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) unknown yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. J. O'Neill M. D.

6/16, 1924 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral DATE OF BURIAL, June 16, 1924

20-UNDERTAKER: George L. Schwab ADDRESS 1101 Eutaw Pl.

IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87864

CERTIFICATE OF DEATH.

101 901 D 87864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 Stockton ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosie Thompson,

(a) RESIDENCE NO. 113 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Blk	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Thompson,

6 DATE OF BIRTH (month, day, and year) Dec 15. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	28	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home, duties

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Hertford Co

PARENTS

10 NAME OF FATHER John Tate.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Harry Thompson Sr 113 Stockton St

15 JUN 16 1924 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1924.

17 I HEREBY CERTIFY That I attended deceased from June 5, 1924. to June 13. 1924.

that I last saw her alive on June 12, 1924.

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Acute Lo Grippe

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exa.

(Signed) Chas. Norton, M. D.

, 19 (Address) 888 N. Carlton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kinsale Va

DATE OF BURIAL June 16th 1924

20 UNDERTAKER A Jones

ADDRESS Kinsale Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87865

CERTIFICATE OF DEATH.

123 D 87865

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helena Placovich

(a) RESIDENCE No. 1308 Rutger Place WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Serbia

PARENTS

10 NAME OF FATHER Mitra Ogavonovich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Serbia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Serbia

14 Informant Rada Placovich

(Address) 1308 Rutger Place

15 Filed JUN 16 192[illegible] ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-18, 1924, to 6-14, 1924.

that I last saw her alive on 6-14, 1924.

and that death occurred, on the date stated above, at 10.40 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cholecystitis (duration) 2 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-21-24

Was there an autopsy? no Removal of gall stones

What test confirmed diagnosis? Clinic — Lab., exam.

(Signed) Isidor S. Fry, M. D.

June, 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 16th 1924

20 UNDERTAKER A Jones

ADDRESS H L Gelsen

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 M.

D 87866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

D 87866

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 208 E Cross ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Maguire

(a) RESIDENCE NO. 208 E Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Maguire

6 DATE OF BIRTH (month, day, and year) Sept. 2nd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant George Maguire

(Address) 208 E Cross

JUN 16 1924

ROBERT F. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1924, to June 14th 1924.

that I last saw h.. alive on June 13th, 1924.

and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus of

Long (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Poulton M. D.

6/16, 1924 (Address) 3707 Hanson Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park.

DATE OF BURIAL 6-16 1924

20 UNDERTAKER E. B. Harle

ADDRESS 1136 E Lexington St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87867

CERTIFICATE OF DEATH.

90 D 87867

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 Church St. Curtis Bay. ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ladislaw Bernady.

(a) RESIDENCE NO. 17 Church St. Curtis Bay. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? 20 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced, WIFE (or HUSBAND) of Frances Bernady.

6 DATE OF BIRTH (month, day, and year) March, 3, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Frances Bernady. (wife)
(Address) 17 Church St. Curtis Bay.

15 JUN 16 1924 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt, M. D. (Coroner.)

June 15. 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL June 17 1924

20 UNDERTAKER Frank Crook Son — ADDRESS 1906 Eutaw

TION is very important. See instructions on back of certificate.

Spec.-1-10-21 M&T 1500 Blks.

D 87868 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 87868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital, 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John B. Brown.

(a) RESIDENCE NO. 536 E. 22nd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Alice G. Brown

6 DATE OF BIRTH (month, day, and year) July 3rd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John B. Brown

9 BIRTHPLACE (city or town) Centerville (State or country) Maryland

PARENTS

10 NAME OF FATHER John B. Brown

11 BIRTHPLACE OF FATHER (city or town) Centerville (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie Bysam

13 BIRTHPLACE OF MOTHER (city or town) Centerville (State or country) Maryland

14 Informant Alice G. Brown (Address) 536 ~~ROBERT R. KRAUTER,~~

15 Filed JUN 16 1924 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.15.24

17

I HEREBY CERTIFY, That I attended deceased from 6.7.24 19.... to 6.15.24 19....

that I last saw h~~im~~ alive on 6.15.24 19....

and that death occurred, on the date stated above, at 8:00 a m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 6.10.24

Was there an autopsy? No

What test confirmed diagnosis? Clynical.

(Signed) Jno A Tompkins, M. D.

19 (Address) 3 N Eutaw Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St John Cemetery Ellicott City	June 17 1924
20 UNDERTAKER	ADDRESS
Henry Jenkins Sons Co	Orchard & Mt Colleb

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

87869

CERTIFICATE OF DEATH.

91-002 D 87869

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E North Ave ST., 17 WARD)

2-FULL NAME Mary Brinkley Boggs.

(a) RESIDENCE No 100 E North Ave ~~St.~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Single

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of: Single

6 DATE OF BIRTH (month, day, and year) Jan 18th 1862

7 AGE: Years 62; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Sommerset Co Maryland

PARENTS

10 NAME OF FATHER: Samuel S Boggs.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sommerset Co Maryland

12 MAIDEN NAME OF MOTHER: Sarah A Brinkley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sommerset Co Maryland

14 Informant: Ann. F. Boggs.

(Address): 100 E North ave

15 JUN 16 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1924

17 I HEREBY CERTIFY, That I attended deceased from DECEMBER 1st, 1917, to June 16th, 1924, that I last saw h[illegible] alive on June 14th, 1924, and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

at least since Dec. 1917

(duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer M. D.

June 16th, 1924 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 17th 24
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Son	Orland & Calhoun Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87870

CERTIFICATE OF DEATH.

74-001

D 87870

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Bell Ave. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Wolfe.

(a) RESIDENCE. NO. 1718 Bell St. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida B. Madary

6 DATE OF BIRTH (month, day, and year) May 10. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shifty clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer B. & O. R. R. Co.

9 BIRTHPLACE (city or town) (State or country) Fredrick Co. Md.

PARENTS

10 NAME OF FATHER W^m. Wolfe.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredrick Co. Md

12 MAIDEN NAME OF MOTHER Susan Hyatt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredrick Co. Md

14 Informant Mrs. H. H. Smith.
(Address) 1718 Bell Ave

JUN 16 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 15, 1924, that I last saw h^m alive on June 14, 1924, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) W^m. Deaton, M. D.

6.15. 1924 (Address) 638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Marvin's Chapel Emmitsburg, Fred Co. Md.	June 18 1924
20 UNDERTAKER Chas. L. Stevens	ADDRESS 150 Fort Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87871

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87871

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Kramer

(a) RESIDENCE No. 630 S. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) [illegible]

14 Informant Municipal Hospital Records

(Address)

N1 6 1924

Robert P. Harrison, .19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 8 1924

17 I HEREBY CERTIFY, That I attended deceased from 5 - 1, 1924, to 6 - 8, 1924.

that I last saw him alive on 6 - 8, 1924,

and that death occurred, on the date stated above, at 9 40 a. m.

The CAUSE OF DEATH* was as follows:

Senile Debilitation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronch. Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sol

(Signed) Claude A. Dorsey, M. D.

6 - 9. 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart.	6/10/24 19
20 UNDERTAKER	ADDRESS
J. J. Doheny & Sons	13 18 Light

mation should be carefully supplied. AGE should be stated EXACTLY. Every ... of infor-
CAUSE OF DEATH in plain terms, so that it ... should state
TION is very important. See instructions on back of certificates. ... that it may be properly classified. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87872

CERTIFICATE OF DEATH.

D 87872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 9 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia MacKenzie

(a) RESIDENCE No. 2347 Taylor ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	83			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs John MacKenzie
(Address) 1457 Calvert St

15 Filed JUN 16 1924, 192 Robert P. Harrison,
Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock - Fract Skull & wrist - accidentally fell down stairs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Mason M. D.
(Coroner.)

6-15-, 192 4 (Address) 508 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Govans	June 17 1924
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87873 ✓ D 87873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

City of BALTIMORE: (No. 1822 Pennsylvania Ave St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris V. Buckingham

(a) Residence No. 1822 Pennsylvania St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 10—1913

7-AGE, 10 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer) Girl

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm J. Buckingham

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER, Daisy Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Mary E. Mills

(Address) 1822 Pennsylvania

15- Dec 6 1924, Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 14-1924

17- I HEREBY CERTIFY, That I attended deceased from Febry 11, 1924, to June 14, 1924, that I last saw h[illegible] alive on June 14 1924 and that death occurred, on the date stated above, at 7 10 P m.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism (Recurrent)

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

6.14, 1924 (Address) 1837 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 6-17 1924
Cathedral Cem	
20-UNDERTAKER Wm Corle	ADDRESS 502 E North

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-18—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87874

CERTIFICATE OF DEATH.

D 87874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 553 W. Barre ST.: 7W WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Edwin Bishop

(a) RESIDENCE. No. 553 W. Barre ST., WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Last Employment Clerical

(b) General nature of industry, business, or establishment in which employed (or employer) L

(c) Name of employer

009

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William D. Bishop

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Walsh

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant (Address) Jos S Knapp 713 Homestead St. City

Filed JUN 16 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1924, to June 14, 1924, that I last saw him alive on June 14, 1924, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Test

(Signed) J. M. Dellett, M. D.

Jun 15, 1924 (Address) 624 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dulaney Cemetery	June 17, 1924
20 UNDERTAKER	ADDRESS
Wm. Cook & or E. Cook Sr	

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87875 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Jourdan

(a) RESIDENCE NO. Towson Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred None yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Harriet Jourdan

6 DATE OF BIRTH (month, day, and year) March 29, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mc Jempfer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wademan Jourdan

11 BIRTHPLACE OF FATHER (city or town) Balto. Co., (State or country) U.S. Md.

12 MAIDEN NAME OF MOTHER Martha Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Md.

14 Informant Harriett M Jourdan (Address) Lochraven Md.

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1924, to June 14, 1924, that I last saw him alive on June 14, 1924, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

about (duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? yes

What test confirmed diagnosis? Spinal puncture

(Signed) Harry McAllen, M. D.

, 19 (Address) 1315 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 17 1924
20 UNDERTAKER	ADDRESS
Wm. Cook	502 E. Fayette

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87876

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph Hosp (Street) 8 (WARD)

2-FULL NAME Mr John T. Griffin

(a) RESIDENCE NO. 1611 No Bond St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Agnes Griffin

6 DATE OF BIRTH (month, day, and year) 1 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Con Gas + Elec Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER James Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Gaffney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A. Griffin

(Address) 1611 N Bond St

15 FILED JUN 16 1924 Robert P. Harrison, Registrar

Burial Permit Clerk's

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17 I HEREBY CERTIFY, That I attended deceased from May 22nd, 1924, to June 14, 1924, that I last saw h in alive on June 14th, 1924, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-4-24

Was there an autopsy? Yes

What test confirmed diagnosis? Oper.

(Signed) A C Manninger M. D.

June 14 1924 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL June 17 1924

20 UNDERTAKER P. A. Krause & Son

ADDRESS 703 Hamm

JUN 16 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shou... the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Blks.

D 87872 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87872

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 221 Rock St., 18 Ward) Registered No.....

2-FULL NAME James Butler

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 221 Rock St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1871

7-AGE.	If LESS than 1 day.
53 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Butler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Annie Marshall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Mary Harrison
(Address) 221 Rock St

15- Robert F. Harrison, 192
Registrar.
Burial Permit Clerk

N 1 67924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 13, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1924 to June 13, 1924
that I last saw him alive on June 13, 1924
and that death occurred, on the date stated above, at 3.50 p.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Hemorrhoids
(Duration) yrs. mos. 2 3 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. Carey M. D.
, 19 (Address) 703 Druid Pk

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	June 16, 1924
20-UNDERTAKER.	ADDRESS.
Brown & Ireland	114 N. Howard St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87878

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 Alvin St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Mayers

(a) Residence No. 327 Colvin St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 1868

7-AGE. 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). 0 10

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto. Md
(State or Country),

PARENTS.

10-NAME OF FATHER, Alfred Green

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Annie Louise Green

13-BIRTHPLACE OF MOTHER (city or town) Md
(State or Country),

14-(Informant). Alfred Green

(Address) 1215 E. Madison St

15-Filed JUN 15 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 14/24

17- I HEREBY CERTIFY, That I attended deceased from June 4 1924 to June 14 1924

that I last saw her alive on June 13 1924

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

Dropsy (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Obstruction of heart

..... (Duration) ..... yrs. ..... mos. 10 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) J. Edward Fowler M. D.

6-14, 1924 (Address) 1612 E. Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Lawn	6/17th 1924
20-UNDERTAKER.	ADDRESS
Jas. M. Shinnick	1625 E. Madison St

Filed JUN 15 1924

Burial Permit Clerk.

Write plainly. Use typewriter if convenient. Fill all blanks. Use "None" or "Unknown" where necessary. Supply information requested EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Follow instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 115 E. Barney ST., 24 (WARD)

REGISTERED NO. 74-036

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Flemmitt

(a) RESIDENCE NO. 115 E Barney ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. L. Flemmitt

6 DATE OF BIRTH (month, day, and year) July 8/1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Robert Clardy

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Annie McCabe

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Mrs Mooney Cook

(Address) 1838 Eight St

N 1 6 1924

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924

17

I HEREBY CERTIFY, That I attended deceased from June 14. 1924 to June 15. 1924.

that I last saw h alive on June 15. 1924

and that death occurred, on the date stated above, at 5- N m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. E. R. Campbell, M. D.

16. 1924 (Address) 1644 E Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odd Fellows Cem	6/17 1924
20 UNDERTAKER J. F. Tabler Sons	ADDRESS 1308 Eight St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

8-4-D 87880

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87880

CERTIFICATE OF DEATH.

49

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Franklin Square Hospt ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary T O'Dea

(a) RESIDENCE. N d150 Carroll St ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rodger O'Dea

6 DATE OF BIRTH (month, day, and year) Feb 28 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marry Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Reuling
(Address) 507 Scott St

15 Filed JUN 16 1924 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 15, 1924, that I last saw her alive on June 15, 1924, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Hematuria

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscope

(Signed) [illegible] M. D

6.15.24 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 6/18 24

20 UNDERTAKER [illegible] — ADDRESS 502 E 4th

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on ... s on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 8788E

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8788E

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 5 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Birley.

(a) RESIDENCE NO Levering House, 100 N. Front St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 8 mos. ds. How long in U. S., If of foreign birth? ---- yrs. ---- mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October -- 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	-----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sheet metal worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

884

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Birley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eliza Fee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant William Birley. (brother)
(Address) 451 Pinkney Place.

15 Filed JUN 16 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage,
probably due to accidental fall.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt, M. D.
(Coroner.)

June, 16, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Woodlawn	6-11 1924
20 UNDERTAKER	ADDRESS
Wm Cook	602 E Mulb

(1) Means and Nature of Injury should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21– E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87882

CERTIFICATE OF DEATH.

X 44 D 87882

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 519 E 22nd St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jesse E Gosnell

(a) Residence No. 519 E 22nd St., Ward Mt. Airy Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (~~Write the~~ word): Widower

5a-If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Mary E Gosnell

6-DATE OF BIRTH (month, day and year) July 6, 1854

7-AGE. 69 yrs. 11 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Self 086
(c) Name of employer: Self

9-BIRTHPLACE (city or town) Carroll Co, Md
(State or Country).

PARENTS.

10-NAME OF FATHER. John Gosnell

11-BIRTHPLACE OF FATHER (city or town) Carroll Co, Md
(State or Country).

12-MAIDEN NAME OF MOTHER. Ruth Leatherwood

13-BIRTHPLACE OF MOTHER (city or town) Carroll Co, Md
(State or Country).

14-
(Informant) A F Brener
(Address) 519 E 22nd St

15-
Filed JUN 16 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 16 1924

17- I HEREBY CERTIFY, That I attended deceased from February 12th 24 to June 16th 1924, that I last saw h. alive on June 16th 1924, and that death occurred, on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Carroll Co. Md

Did an operation precede death? Date of

Was there an autopsy?

What ~~was~~ confirmed diagnosis ~~of tumor contents~~ X ray & Analyses

(Signed) C E Fahey M. D

June 16 1924 (Address) 521 E. Lanvale

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet, Mt Airy	June 18 1924
20-UNDERTAKER.	ADDRESS
Wm. Leavell	521 E Lanvale St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87883

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D 87883

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 18 N. Chester Street St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Strauss

(a) Residence No. 18 N. Chester St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day.
75 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Harry Strauss

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Pearl ---------

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant) J. Leivs

(Address) 1439 E. Balto. St.

15- JUN 17 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 17-24

17- I HEREBY CERTIFY, That I attended deceased from April 2 19 24 to June 17 19 24 that I last saw her alive on June 16 — 19 24 and that death occurred, on the date stated above, at 8.30A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension

Bronchial Asthma

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Forensic

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benjamin M. Apple M. D

6. 17. 1924 (Address) 3028 E. Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Lebanon Cem.	June 17 1924

20-UNDERTAKER,	ADDRESS
Jos. Lewis	1439 E. Balto. St.

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87884

CERTIFICATE OF DEATH.

90 D 87884

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 Riggs Ave. ST.; 16 WARD)

2-FULL NAME Henry Wright

(a) RESIDENCE NO. 1710 Riggs Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5n If married, widowed, or divorced HUSBAND of (or) WIFE of Lettie Wright

6 DATE OF BIRTH (month, day, and year) of known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robert Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nellie Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Anne Gusere

(Address) 1710 Riggs Ave.

15 Filed JUN 7 1924 18 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 12, 1924, to June 14, 1924.

that I last saw him alive on June 14, 1924.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M. D.

6/14, 1924 (Address) 1928 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hebron Cem St Mary Co Md

DATE OF BURIAL 6/17 1924

20 UNDERTAKER Mrs James H. Dennis per T. E. Kelson

ADDRESS 1303 Pressman

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-901

D 87885

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 Canal ST., 11 WARD)

2-FULL NAME Richard Watts

(a) RESIDENCE NO. 343 Canal ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Watts

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cotton 040

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Edith Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant James Lounsbury (Address) 343 Canal ave.

15 Filed JUN 7 1924 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/24

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1924 to June 6th 1924 that I last saw h.. alive on June 6th 1924 and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. Lee Ellis M. D.

6/6 19 24 (Address) 524 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	June 14 24

20 UNDERTAKER Samuel Wensley ADDRESS [illegible]

mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of c

GOVERNMENT RECORD. Every item of in... d be stated EXACTLY. PHYSICIANS should state be properly classified. Exact statement of OCCUPA- of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87886

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87886

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 916 Stirling ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Brown

(a) RESIDENCE. No. 916 Stirling ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of Amelia Brown (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Cecelia Swann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Amelia Brown

(Address) 916 Stirling St.

JUN 17 1924

Registrar

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1924

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 13, 1924.

that I last saw him alive on June 13, 1924.

and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

(Address) 120 Eisguild St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetary	June 17 1924
20 UNDERTAKER	ADDRESS
Jos. H. Rochester	1413 Hanover St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be carefully supplied.

Spec—12-23-21—E.B.P.S.—400 Bks.

D 87887

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87887

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4812 Hendale Ave St., 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Geoge Maas

(a) Residence No. 4812 Hendale Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-~~SEX~~ Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Louis P. Maas

6-DATE OF BIRTH (month, day and year) Jan-10-1868

7-AGE. 56 yrs. 5 mos. 4 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Stephen Geoge

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Schaumberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14-

(Informant) Louis Maas

(Address) 4812 Hendale Ave

15-

Filed JUN 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/14/24

17- I HEREBY CERTIFY, That I attended deceased from Dec 1 1923 to June 14 1924

that I last saw h[illegible] alive on June 14 1924

and that death occurred, on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrage

1/2 Hour

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(Duration) 1 yrs. 6 mos.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of 3/1/23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) W J Eckelt M. D

, 19 (Address) 6 E Read St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cem June 17 1924

DATE OF BURIAL,

20-UNDERTAKER, Wm J Eichenlaub

ADDRESS Nath St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ D 87888

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 215 N.Carrollton Ave. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H.Kreh,

(a) Residence No. 215 N.Carrollton Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sadie R.Kreh,

6-DATE OF BIRTH (month, day and year) Jan.16.1870

7-AGE,	If LESS than 1 day,
54 yrs. 4 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Himself

9-BIRTHPLACE (city or town) (State or Country). Frederick Md.

PARENTS.

10-NAME OF FATHER Lewis W.Kreh,

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Frederick Md.

12-MAIDEN NAME OF MOTHER Eva Faulk,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Frederick Md.

14- (Informant) Sadie R.Kreh,

(Address) 215 N.Carrollton Ave.

15- FUNERAL DIRECTED BY JUN 17 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) JUN 15 1924

17- I HEREBY CERTIFY, That I attended deceased from June 5, 19 24, to June 15, 19 24

that I last saw h...live on June 15, 19 24

and that death occurred, on the date stated above, at 3.40 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebralis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

JUN 16 1924 (Signed) J. J. Kreh M. D.

19 (Address) 14 so Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park DATE OF BURIAL, JUN 18 1924 19....

20-UNDERTAKER Geo N Little ADDRESS 2700 EDMONDSON AVE.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87889

CERTIFICATE OF DEATH.

D 87889

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 309 S. East Ave St., 7th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Donohue

(a) Residence No. 309 S. East Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Donohue

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE. 81 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER. Patrick O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Not Known.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) P. J. Donohue

(Address) 309 S. East ave.

JUN 7 1924

Filed 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 15th 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1st, 1924 to June 15th, 1924

that I last saw h. alive on June 15th 1924

and that death occurred, on the date stated above, at 12,15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arteritis

Hypertrophy

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cong. Hy. Enlargement

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Geo. Gerstenberger M. D.

, 19 (Address) 240 Mt. Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral Cem	June 18, 1924
20-UNDERTAKER. J. J. Moran	ADDRESS 200 E. Balto St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 87890

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Anerosity Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME James F. Fermoyle

(a) RESIDENCE No Annapolis Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Lineman
(b) General nature of industry, business, or establishment in which employed (or employer) Chesapeake Bay Power Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Md

PARENTS

10 NAME OF FATHER Wm H. Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Minnie Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co Md

14 Informant Mrs Jas F Freeman (Address) Annapolis Md.

15 Filed JUN 17 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ or inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Came in contact with live wire while at work (duration) yrs. mos. ds.

(Signed) [illegible], M. D. (Coroner.)

6-17, 1924 (Address) 117 W Dorchester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	6/17 1924
20 UNDERTAKER Jas S. Taylor Sons	ADDRESS Annapolis Md

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- ...ay be properly classified. ...PHYSICIANS should state ...in plain terms, so that it

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87891

CERTIFICATE OF DEATH.

74-005 D 87891

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 841 E Chase St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Mary Ellen Pemberton

(a) Residence No. 841 E Chase St., 10 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 1, 1839

7-AGE, 85 yrs. 1 mos. 14 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Louisville, Kentucky

PARENTS.

10-NAME OF FATHER, McLaughlin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Anderson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Helen Pemberton

(Address) 35 Delaware Ave Pittston Pa

15- JUN 17 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 15, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 15, 1924

that I last saw h[illegible] alive on June 15, 1924

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Agr. High Blood Press

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis? Clinical

(Signed) T. K. Gorsch, M. D.

June 16, 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral — DATE OF BURIAL, June 18, 1924

20-UNDERTAKER, J. J. C. Wiedefeld — ADDRESS 917 Fremont Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87892

CERTIFICATE OF DEATH.

47 D 87892

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 10 WARD)

2-FULL NAME Mary O'Brien

(a) RESIDENCE NO. 1724 Ensor ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew O'Brien

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Work 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) [redacted]

(State or country)

12 MAIDEN NAME OF MOTHER Mary Fitzmurray

13 BIRTHPLACE OF MOTHER (city or town) Ire

(State or country)

14 Informant Mrs. Grady

(Address) 1206 Ensor

15 Filed JUN 7 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to June 16, 1924, that I last saw her alive on June 16, 1924, and that death occurred, on the date stated above, at 2 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Recurrent carcinoma breast

metastases to pleura

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma breast

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1724 Ensor St.

Did an operation precede death? Yes Date of Dec. 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Typical evidence

(Signed) Geo. B. Sybert, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 18 1924

20 UNDERTAKER J. C. Windfield ADDRESS 914 Gramont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

Emily Mullen

D 87893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Kennedy Sanitarium Athol

REGISTERED No. C 90

CITY OF BALTIMORE: (No. Fulton Road ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Emily Neal Mullen

(Residence in Baltimore: No. Kennedy Sanitarium Athol, Fulton Road St., abt 1 year yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Dec (Month) ..... (Day), 1848. (Year)

7-AGE,	If LESS than 1 day,
75 yrs. 6 mos. ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Lady
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Norfolk, Va

PARENTS.

10-NAME OF FATHER, Harry Hughes

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Emily Neal

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James M. Mullen

(Address) 1 Norfolk Va

Filed JUN 17 1924, 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 3 1924, to June 16 1924, that I saw h.. alive on June 16 1924, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Cardio Constriction

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(Duration) yrs. 5 mos. ds.

(Signed) Alfred J. Carleton M. D.

June 16, 1924 (Address) Athol Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 8 yrs. mos. 13 ds. In the State 8 yrs. mos. 13 ds.

Where was disease contracted, if not at place of death? Norfolk Va

Former or usual residence .. ..

19-PLACE OF BURIAL OR REMOVAL, Norfolk Va — DATE OF BURIAL, June 17, 1924

20-UNDERTAKER J. C. Mitchell — ADDRESS 2011 W Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87894

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1538 McElderry ~~Johns Hopkins Hospital.~~ ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Richardson

(a) RESIDENCE NO..... ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Black | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years ..... Months ..... Days ..... If LESS than 1 day, 12 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Sonnie Bush

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Cora Richardson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant (Address) Johns Hopkins Hospital

15 Robert P. Harrison, ... 19.....
Registrar

No N1 71924 5/8 Burial Permit Clerk

Returned through the mail

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 18 .19 24. to Feb 18 .19 24.

that I last saw her dead alive on Feb 18 .19 24.

and that death occurred, on the date stated above, at 6 00 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Maternal Syphilis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) E E Duncan —, M. D.

2/18. 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

JOHNS HOPKINS HOSPITAL

JOHNS HOPKINS HOSPITAL

JUN 17

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87895

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 57 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence McJunkin

(a) RESIDENCE NO. 1723 Maryland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Jess McJunkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Lizzie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Municipal Hospital Records (Address)

15 Filed 7 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-9, 1924 to 6-14, 1924

that I last saw him alive on 6-13, 1924

and that death occurred, on the date stated above, at 4:45 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1-2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Lab.

(Signed) Claude S. Brace, M. D.

(Address) Municipal Hospital 6-14 1924

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS N17

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should specify CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87896

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87896

CERTIFICATE OF DEATH.

24 90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1645 Jackson St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura A Niemann

(a) Residence No. 1645 Jackson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of August Niemann

6-DATE OF BIRTH (month, day and year) Feb 6 - 1856

7-AGE.	If LESS than 1 day,
68 yrs. 4 mos. 10 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER. William Riehl

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER. Caroline Neuman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) August Niemann

(Address) 1645 Jackson St.

15- Filed 6/19 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 16, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 29th " 1924 to June 16th " 1924

that I last saw her alive on June 15th " 1924

and that death occurred, on the date stated above, at 5 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Aortic Regurgitation

of Heart

(Durntion) — yrs. 1 mos. 18 ds

CONTRIBUTORY (Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Harry Weibell M. D.

6/17 1924 (Address) 1324 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cedar Hill Cem	6/19 1924
20-UNDERTAKER.	**ADDRESS**
J. Frew McCully	130 E. Fort

N 1 71924

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87897

101-001

D 87897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 622 S. Decker Ave. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Evelyn Bachmann.

(a) Residence No. 622 S. Decker Ave St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	S

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 3-1922

7-AGE. 2 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER John H. Bachmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Carrie K Eydelotte

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) John H. Bachmann

(Address) 622 S. Decker Ave.

15- Filed June 19 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 16-1924

17- I HEREBY CERTIFY, That I attended deceased from June 10 1924 to June 16 1924

that I last saw h. alive on June 16 1924

and that death occurred, on the date stated above, at 7.55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J Bellis M. D

June 16, 1924 (Address) 1900 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Pace & Heartman	June 18, 1924
20-UNDERTAKER. Lilly & Zeile	ADDRESS 403 S. Wolfe St

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87898 ✓ 90 D 87898

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7135 Sinclair Ave. St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Champness

(a) Residence No. 7135 Sinclair Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Champness

6-DATE OF BIRTH (month, day and year) June 13-1873.

7-AGE. 51 yrs. 0 mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

10-NAME OF FATHER. Valentine Goetz.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Caroline Klipper.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto. Md.

PARENTS.

14- (Informant) Robert Champness

(Address) 7135 Sinclair Ave.,

15- Filed Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 15-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 1 1923 to June 15 1924 that I last saw h.. alive on June 15 1924 and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm R. Geraghty M. D

6/16 1924 (Address) 703 E Preston St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. June 18 1924

20-UNDERTAKER. Lilly & Zeller ADDRESS 403 S Wolfe St.

N 1 71924 Burial Permit Clerk.

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—8-24-14—M. & T.—2000 Bks.

(Myles Jennings)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 87899

CERTIFICATE OF DEATH.

90 D 87899

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W 25 15 Hollins ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

2-FULL NAME Myles J. Jennings

(Residence in Baltimore: No. 2515 Hollins St.; 5 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-CONDITION, (Write the word.) Married

6-DATE OF BIRTH, — — 1877
(Month) (Day) (Year)

7-AGE, 47 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Ironworker
(b) General nature of industry, business, or establishment in which employed (or employer) Ck

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Thos Jennings

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary Manning

13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Jennings

(Address) 2515 Hollins St.

15-

Filed ....., 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16th, 1924.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 16th 1924, to June 16 1924, that I saw him alive on June 16th 1924, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leonard E. Beach M. D.

Jan. 17., 1924 (Address) 2331 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenlawn | DATE OF BURIAL, 6/18., 1924

20-UNDERTAKER J. Fitzgerald | ADDRESS 1518 Eight St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 87900 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Pronounced Dead at 6 X 188-903

City of BALTIMORE: (No. Bay View Hospital St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry S Wendenath

(Residence in Baltimore: No. Savannah Ave Essex 8 yrs., 4 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Jan. (Month) 12 (Day) 1916 (Year)

7-AGE. 8 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country) Balto Co

PARENTS.

10-NAME OF FATHER. John Wedenath

11-BIRTHPLACE OF FATHER. (State or Country) Balto City

12-MAIDEN NAME OF MOTHER. Anna Bauer

13-BIRTHPLACE OF MOTHER. (State or Country) Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H Wedenath

(Address) Essex Balto Co.

15- Filed ..... 192.....

Robert P. Harrison,
Registrar.
Burial Permit Clerk.

N 1 7 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 15 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull
Cerebral Hemorrhage accident
(Struck while on Road)
(Duration) yrs. mos. 1 hr

CONTRIBUTORY (Secondary) Hemorrhage in
Brain (Duration) yrs. mos. 1 hr

(Signed) James McFeeley M. D.
(Coroner)

June 16 1924 (Address) 702 Chestnut

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Essex Md.

19-PLACE OF BURIAL OR REMOVAL. Zion Lutheran Cemetery DATE OF BURIAL. June 18 1924

20-UNDERTAKER. Fred Lessahn & Sons ADDRESS Fullerton

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Collins)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8790 F

D 8790 F

122-001 V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 27 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Collins

(a) RESIDENCE NO. 4 9th (Usual place of abode) ST. Alhambra WARD

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 866

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer Burroughs Adding Machine Co

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER James Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McGann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record (Address)

15 Filed JUN 1 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/1924

17

I HEREBY CERTIFY, That I attended deceased from 6/8/24, 19..., to 6/16/24, 19...

that I last saw h~~im~~ alive on 6/16/24, 19...

and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver

(duration) ? yrs.) mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 6/8/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Necropsy

(Signed) K. W. Dolley, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Philadelphia Pa	June 19th 1924
20 UNDERTAKER	ADDRESS 225 St
Wm J. Hartwell & Bro	Baltimore MD St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87902

CERTIFICATE OF DEATH.

100 D 87902

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benedict Smith

(a) Residence No. 672 Haw Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1876

7-AGE. 48 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

0440

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Lee

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs. C. Smith

(Address) 672 Haw St

15- Filed 1 7 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 14 1924

17- I HEREBY CERTIFY, That I attended deceased from June 12, 1924, to June 14, 1924, that I last saw him alive on June 14, 1924, and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Urinary Extravasation

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 14 24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pathological findings

(Signed) Wm. P. Fallon M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. MT Auburn Cem

DATE OF BURIAL, 6/18/24

20-UNDERTAKER David Fallon

ADDRESS 916 Eutaw

IN ORDER TO INSURE PROPER AND SPEEDY REGISTRATION, PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important. Use plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec-12-23-21—E.B.R.S.—400 Bks.

D 87903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87903

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH

City of BALTIMORE: (No. 3828 Fait Ave St., 96 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Bertha Eckstein

(a) Residence No. 704 S. Clinton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Eckstein

6-DATE OF BIRTH (month, day and year) Oct 7. 1873

7-AGE, 00 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Henry Pepper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lost River

12-MAIDEN NAME OF MOTHER, Mary Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Anna Kopnewitz

(Address) Stemmers Run

15- Filed JUN 17 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 16-24

17- I HEREBY CERTIFY, That I attended deceased from 6/16 19.24 to 6/16 19.24

that I last saw her alive on 6/16/24 19.....,

and that death occurred, on the date stated above, at 5 .....m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) J. H. McGarrell, M. D.

19 (Address) 630 S 3rd St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, June 19, 1924

20-UNDERTAKER, John Ellert — ADDRESS 2008 Orleans

SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificates.

D. 87903 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 87903

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1828 Fort Ave St., Ward) (If death occurred hospital or institu give its NAME in of street and numbe fill out No. 18.)

2-FULL NAME. Bertha Eckstein

(Residence in Baltimore: No. 404 S Clinton St St.; yrs., mos.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Widow

6-DATE OF BIRTH, Oct (Month) 4 (Day) 1873 (Year)

7-AGE. 50 yrs. 8 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, Henry Pepper

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary Miller

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stratmann

(Address) Sparrows Point

15-

Filed ..... 192 .....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day) 19 (Y

17- I HEREBY CERTIFY, That I took charge remains described above, held an Inquest (Inquest, autopsy or inqu thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) 2 yrs. mos.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos.

(Signed) James McFarlan (Coroner.)

June 19 24 (Address) 700 E Chas

*State the Disease Causing Death, or, in deaths from Causes, state (1) Means of Injury; and (2) whether Acc Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. sients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BUR

20-UNDERTAKER,	ADDRESS

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87904

CERTIFICATE OF DEATH.

159 - 103

D 87904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Audrey Marie Forrester

(a) RESIDENCE NO. 429 S Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 hrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16/924

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
				10

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John S. Forrester

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Theresa A. Vogel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs John S Forrester
(Address) 429 S Paca

15 Filed 1 7 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock
Burns

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John J. Morrissey, M. D.
(Coroner.)

June 17, 1924 (Address) 3692 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL June 18 1924

20 UNDERTAKER John F Denny — ADDRESS 715 Lydia St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87905

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87905

CERTIFICATE OF DEATH.

6-05

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 308 N Bridle ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis N. Thomas

(a) RESIDENCE NO. 308 N Bridle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 1873

7 AGE — Years: 51 — Months: 3 — Days: — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stable boss

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Walbrook Ice & Dairy Co.

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Augustus Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Rozella Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Harriet Pigeon

(Address) 763 Hunt St

15 Filed ....., 19.... Robert P. Harrison

Registrar

JUL 7 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1924

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1924, to June 16, 1924, that I last saw him alive on June 15, 1924, and that death occurred, on the date stated above, at 6.30 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

June 19 24 (Address) 2608 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. — DATE OF BURIAL: June 8 1924

20 UNDERTAKER: Samuel Stanley — ADDRESS: 1108 N Bridle

mation should be carefully supplied. AGE should
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back

Rec'd 12-23-21—E.B.R.S.—400 Blks.

D 87906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1419 Mc Henry St St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael J. Egan

(a) Residence No. 1419 Mc Henry St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 1 mos. 10 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mabel Egan

6-DATE OF BIRTH (month, day and year) May 6 1876

7-AGE. 48 yrs. 1 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Egan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Ward

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs Mabel Egan

(Address) 1419 Mc Henry St

15- Robert P. Harrison, Registrar.

N 1 71924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 16-24

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to June 16, 1924, that I last saw him alive on June 16, 1924, and that death occurred, on the date stated above, at 3.0 m.

The CAUSE OF DEATH* was as follows:

Carcinomata of Stomach - Metastasis

(Duration) 5 mos.

CONTRIBUTORY (Secondary) Endocarditis, Pulmonary Edema (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Norbert C. Mitsch M. D.

6/17, 1924 (Address) 2151 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cemetery	June 17, 1924

20-UNDERTAKER.	ADDRESS
Harry A Comacook	4204 Redgewood Ave

EXACTLY. PHYSICIANS should state CAUSE OF DEATH. Exact statement of OCCUPATION is very important. in plain terms, so that it may be properly classified. instructions on back of certificates.

Cor.—1-12-21—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87907

D 87907

CERTIFICATE OF DEATH.

21

7

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm.H. Pearson

(a) RESIDENCE NO. 1025 N Washington St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 5/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Talmage W. Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Ruth M. Biddison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.Md

14 Informant: Ruth Pearson
(Address): 1025 N. Washington

15 Filed 1 71924 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) undetermined

(duration) yrs. mos. ds.

(Signed) J. S. Wallace, M. D.
(Coroner.)

6/17/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W.L. Carmel Cem — DATE OF BURIAL: June 17 1924

20 UNDERTAKER: Geo M. Fowler & Son — ADDRESS: 811 N. Wolfe

IMPORTANT! See instructions on back of certificate. ... be properly classified. Exact statement ... OCCUPATION is very important!

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 87908

CERTIFICATE OF DEATH.

11-3 D 87908

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James T. Smith

(Residence in Baltimore: No. 1509 Baker St.; 1 yrs. mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Infant

6-DATE OF BIRTH, June (Month) 6 (Day), 1923 (Year)

7-AGE, 1 yrs. mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... infant.

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, William H. Smith

11-BIRTHPLACE OF FATHER (State or Country), St Marys Co Md.

12-MAIDEN NAME OF MOTHER Jannie L. Sorrell

13-BIRTHPLACE OF MOTHER (State or Country), St Mary's Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. Smith

(Address) 1509 Baker St.

15- JUN 18 1924 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 16 (Day), 24 (Year) 191

17- I HEREBY CERTIFY, That I attended deceased from 6-5-24 191, to 6-17-24 191 that I saw h— alive on 6/16-24 191, and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis

(Duration) yrs. mos. 14 da

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 9 ds.

(Signed) W. H. Boykin M. D.

6/17/24, 191.. (Address) 161 S Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Bonnie Brea cemetery.

DATE OF BURIAL, 6/18 1924

20-UNDERTAKER Mrs Jas H. Dennis per J.E. Belson

ADDRESS 1313 Pressman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

118 D 87909

1-PLACE OF DEATH Church Home and Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 8 WARD)

2-FULL NAME Harry D. Depkin

(a) RESIDENCE NO. 1800 Rutland Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced- HUSBAND of (or) WIFE of Louise H. Depkin

6 DATE OF BIRTH (month, day, and year) Feb 13. 1881

7 AGE	Years	Months	Days	If LESS than 1 day,....hrs. or.....min.
	43	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gompertz & Bench

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Depkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elig. Labernagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise H. Depkin

(Address) 1800 Rutland Ave

15 JUN 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 17, 1924,

that I last saw him alive on June 17, 1924,

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Uremia Postoperative

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 1 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of June 11, 1924

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Cayetano Paniello M. D.

6/17, 1924 (Address) Edmund Home and Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 19, 1924
20 UNDERTAKER Mr & Mrs. John W Teufel & Son	ADDRESS 801 W. Fayette

AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

Shug.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87910

CERTIFICATE OF DEATH.

D 87910

X 139

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Monument ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Shug

(a) RESIDENCE NO. 2024 E. Lombard ST., WARD Penna.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barney Shug

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Montbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lewis (Address) 1439 E. Balto.

15 JUN 18 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17 19 24

17 I HEREBY CERTIFY, That I attended deceased from May 28, 19 24, to June 17, 19 24,

that I last saw h[illegible] alive on June 17, 19 24

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

Operation - Hysterectomy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/29/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Stiller Strassburger, M. D.

6/19/1924 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton, Penna. DATE OF BURIAL 6-18-1924

20 UNDERTAKER Jack Lewis, ADDRESS 1439 E. Balto

...nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

17046 D 8791 K

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 8791 K

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., 10 WARD)

2-FULL NAME Albert Price

(a) RESIDENCE NO. 404 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 23-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER B. Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed JUN 18 1924 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16- 1924

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1924, to June 16, 1924

that I last saw him alive on June 16, 1924,

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Tbc. meningitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray

(Signed) H. H. Mitch, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Amelung — DATE OF BURIAL June 18, 24

20 UNDERTAKER Mrs. Ida Snowden — ADDRESS 1775 Eastern Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87912 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 ✓

CERTIFICATE OF DEATH.

Registered No. D 87912

1-PLACE OF DEATH

City of BALTIMORE: (No. Daybrew Hospital St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William Henry Curtis

(Residence in Baltimore: No. 1017 S. Howard St.; Fifty-three yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
33 yrs. ..... mos. ..... ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Common

9-BIRTHPLACE, (State or Country), Balto. City.

PARENTS.

10-NAME OF FATHER. John H. Curtis

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Alice Miller

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Curtis

(Address) 2466 Buckhaven St.

15- Filed JUN 18 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 16 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thomas M. Hunter M. D. (Coroner.)

June 17 1924 (Address) 701 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. 1/2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

1017 S. Howard St.

Former or usual residence ..... " "

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Laurel Cemetery	June 19, 1924

20-UNDERTAKER.	ADDRESS
Mrs. R. G. Elliott	1122 Eutaw Place

state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87913

CERTIFICATE OF DEATH.

90 D 87913

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., 27 WARD)

2-FULL NAME Israel Solomon Williams

(a) RESIDENCE NO. 5207 Vernon ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed JUNT 8 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15 1924

17

I HEREBY CERTIFY, That I attended deceased from 2-14, 1924, to 6-15, 1924,

that I last saw him alive on 6-15, 1924,

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis;
Chronic Myocarditis
Myocardial Insufficiency

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY .....
(Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Claude S. Davis, M. D.

6-16 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn. Cemetery	June 20 1924
20 UNDERTAKER	ADDRESS
Mrs R. G. Elliott	1225 Eastlander

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87914

CERTIFICATE OF DEATH.

101-051

D 87914

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Warner

(a) RESIDENCE NO 216 W Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Ernest Warner

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mary Warner Mother
(Address) 216 W. Biddle St.

15 Filed JUN 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 17 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Un[redacted]t, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Coroner, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) M. Greenfield, M. D. (Coroner.)

6-18, 192 4 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 6 192 4
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1320 Cumberland

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA- may be properly classified, so that it

Cor.—1-12-23—M&T—100 Bks.

D 87915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87915

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. Mercy Hospital. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ermine Viola Bray. (C)

(a) RESIDENCE NO. 330- 22 1/2 St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Married.

5a If married, widowed, or divorced (or) WIFE of William Bray. (C)

6 DATE OF BIRTH (month, day, and year) April 25, 1892.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None. 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Elias Diggs. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A. Ford. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant William Bray. (C) husband.
(Address) 330- 22 1/2 St.

15 Filed JUN 18 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of the liver and kidneys.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

June 16, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 18 1924
20 UNDERTAKER	**ADDRESS**
Mrs. R. G. Elliott	[illegible]

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Lissau

D 87916 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87916

1726

11-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 27 WARD)

2-FULL NAME Mary Lissau

(a) RESIDENCE NO. 302 Nicholson ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19 - 1922

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Otto Lissau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 JUN 18 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 17, 1924,

that I last saw her alive on June 17, 1924

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Influenzal meningitis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Louis

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) H. R. Mock, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 20 1924

20 UNDERTAKER C. H. Dill — ADDRESS 2109 Frederick Ave

No 5765

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87917 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87917

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Jones.

(a) RESIDENCE No. 168 E. Main St S. Logan Ohio.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life 6 mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. 40 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10 NAME OF FATHER John Jones.
11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Ohio
12 MAIDEN NAME OF MOTHER Lucinda Bowe
13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Ohio

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 18 1924, 19 ROBERT R. KRAUTER,
Registrar
Per [illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Sept 13 1924 to June 17 1924
that I last saw him alive on June 17 1924
and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:
Benign prostatic Hypertrophy.
Operated. Cystonephritis
Uremia.
(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Logan Ohio.
Did an operation precede death? yes Date of May 9-1924
Was there an autopsy? Yes.
What test confirmed diagnosis? Kidney & Lung.
(Signed) Robert W. McKay M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Logan Ohio — DATE OF BURIAL Jun 18 1924

UNDERTAKER John O Mitchell — ADDRESS 1301 W Fayette

PHYSICIANS should state EXACTLY CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87918

CERTIFICATE OF DEATH.

454

D 87918

REGISTERED NO.

1-PLACE OF DEATH Church Home and Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME Mrs Margaret A Schneider

(a) RESIDENCE NO. 922 N. Central Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of John G. Schneider Sr.

6 DATE OF BIRTH (month, day, and year) July 26 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Adam Long

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret J. Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mr John G. Schneider Jr.

(Address) 922 N. Central Ave

JUN 18 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1924, to June 17th, 1924, that I last saw her alive on June 17th, 1924, and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Transverse Colon

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of May 7 1924

Was there an autopsy? yes

What test confirmed diagnosis? Operation Autopsy

(Signed) Physician Barnethein, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 20 1924
20 UNDERTAKER	ADDRESS
Henry Hoede Sons	1301 E Eager St

INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87919

CERTIFICATE OF DEATH.

129 D 87919

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Greenway Apartments ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emory Vaughan Webster

(a) RESIDENCE NO. Greenway Apartments ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna Cox Webster

6 DATE OF BIRTH (month, day, and year) October 15th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	66	7	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Deals Island (State or country) Maryland

PARENTS

10 NAME OF FATHER Silas T. Webster

11 BIRTHPLACE OF FATHER (city or town) Deals Island (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Kelly

13 BIRTHPLACE OF MOTHER (city or town) Deals Island (State or country) Maryland

14 Informant Anna Cox Webster (Address) Greenway Apartments

15 JUN 18 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1924, to June 17, 1924, that I last saw h[illegible] alive on June 16, 1924, and that death occurred, on the date stated above, at 1.59 A m.,

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 5 days yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) Jefferies Buck M. D.

6/17 1924 (Address) 1811 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 19 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument St

IMPORTANT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87920

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87920

CERTIFICATE OF DEATH.

X188-003

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Bay view Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna H Kanapka

(Residence in Baltimore: No. New Pittsburg ave Colgate Balto Md St.; yrs., mos. 1 mon)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

6-DATE OF BIRTH. Nov. (Month) 16 (Day) 1916 (Year)

7-AGE.	If LESS than 1 day,
7 yrs. 7 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Co,

PARENTS.

10-NAME OF FATHER, Joseph Kanapka

11-BIRTHPLACE OF FATHER, (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Minn Abramovich

13-BIRTHPLACE OF MOTHER, (State or Country) Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Knapka

(Address) Colgate Balto Co.

15-

Filed JUN 18 1924 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 16 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture, Skull, Severe
Abdominal Injuries
Automobile accident, She
was ran down on street by car
(Duration) yrs. mos.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) James M Fenlon M. D.
(Coroner)
June 17 192 4 (Address) 700 E Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Colgate Balto Co

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Oak Lawn Cem.	June 19 1924

20-UNDERTAKER,	ADDRESS
H. Sander Sons	1310 Eut N

state CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87921 — CERTIFICATE OF DEATH. — 31 D 87921

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 888 W. Baltimore St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman J. Brugmann

(Residence in Baltimore: No. 888 W. Baltimore St.; ...yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	white	Single

6-DATE OF BIRTH, January 25, 1875
(Month) (Day) (Year)

7-AGE, 49 yrs. 4 mos. 21 ds. — If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar maker
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Herman Brugmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Charlotte Brandau

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Julius Brugmann

(Address) 888 W. Balto St.

JUN 18 1924

Filed....., 191.... ROBERT R. KRAUTER, Clerk.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 15, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924, to June 15 1924, that I saw him alive on June 14 1924, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(Duration) — yrs. — mos. 4 ds.

(Signed) Herbert F. Steelman M. D.

June 15, 1924 (Address) 6 E Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, H. C. B. Loudon Park — DATE OF BURIAL, 6.15., 1924

20-UNDERTAKER H. C. Brauning Son — ADDRESS 517 N. Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87922 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3029 Walbrook Av St., 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Elizabeth Everist

(a) Residence No. 3029 Walbrook Av St., 15 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 83 yrs. 6 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Everist

6-DATE OF BIRTH (month, day and year) Nov-29-1840

7-AGE 83 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Harford Co. Maryland.

PARENTS.

10-NAME OF FATHER, Thos. B. Suter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Harford Co. maryland

12-MAIDEN NAME OF MOTHER, Frances Levy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Harford Co. Maryland.

14- (Informant) Mr. Thos. B. Everist (Son)

(Address) Burke Lane - City.

15- JUN 18 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 15/24

17- I HEREBY CERTIFY, That I attended deceased from April 24, 1924, to June 15, 1924, that I last saw him alive on June 15, 1924, and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

8

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteri Sclerosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gunn, M. D.

6/16, 1924 (Address) 6 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery

DATE OF BURIAL, June 17, 1924

20-UNDERTAKER STEWART & HOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE.

In plain terms, so that it may be properly classified. Exact statement of OCCUP
instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87923

CERTIFICATE OF DEATH.

100-06

1-PLACE OF DEATH [illegible] HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Ernest Stanley

(a) RESIDENCE NO. 522 N. Central Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) .....

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 31-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Ernest Stanley

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn —

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Records

(Address) [illegible] HOPKINS HOSPITAL

JUN 18 1924

ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1924

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1924, to June 16, 1924, that I last saw him alive on June 16, 1924, and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Primary

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Thoracic Rickets ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. R. Bagg M. D.

, 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL June 18 1924

20 UNDERTAKER Thos J. G. Locke

ADDRESS 1302 Jeffers

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87924 ✓ 89 D 87924

D 87924

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 3409 Fairview Ave WARD 15)

2-FULL NAME William Oberndorf

(a) RESIDENCE NO. 3409 Fairview Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth M. Oberndorf

6 DATE OF BIRTH (month, day, and year) Oct 18 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dry Goods
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Oberndorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emily Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. ~~Emily~~ R. Oberndorf
(Address) 3409 Fairview Ave

15 JUN 18 1924

ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

June 17, 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL Har Sinai Cem. DATE OF BURIAL 6/19/1924

20 UNDERTAKER Baird Sondheim ADDRESS 118-20 N. Howard St

TION is very important. See instructions on back of certificate.

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87925

CERTIFICATE OF DEATH.

47

D 87925

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5237 (ST.) Ruckstown Rd (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Rose White

(a) RESIDENCE NO. 5237 ST., Ruckstown Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Edward F White

6 DATE OF BIRTH (month, day, and year) Oct 28 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Cyrenda Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Gott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Edward F White

(Address) 5237 Ruckstown Rd

15 Filed JUN 18 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH 6-16

16 DATE OF DEATH (month, day, and year) 6-16 1924

17

I HEREBY CERTIFY, That I attended deceased from March, 1924, to June 16, 1924, that I last saw her alive on June 16, 1924, and that death occurred, on the date stated above, at 7.00 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of breast

(duration) 1-2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & history

(Signed) Henry Pentwell M. D.

6-18 1924 (Address) 3902 Greenland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: June 19 1924

20 UNDERTAKER: W H Marshall — ADDRESS: 339 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87926

CERTIFICATE OF DEATH.

2 9

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1829 Bank St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida . Blachowicz

(a) Residence No. 1829 Bank St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 24 1923

7-AGE. .....yrs. 9 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country) Md

PARENTS.

10-NAME OF FATHER, John. Blachowicz

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Nina. Ponti

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Mr John. Blachowicz

(Address) 1829 Bank Street

15- Filed Robert P. Harrison, Registrar.

JN 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 17 1924

17- I HEREBY CERTIFY, That I attended deceased from June 15, 1924 to June 17, 1924

that I last saw her alive on June 17, 1924

and that death occurred, on the date stated above, at 5 10 P. M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D

6/18, 1924 (Address) 2739 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Stanislaus	June 19, 1924
20-UNDERTAKER.	**ADDRESS**
John M Weber	1803 Bank St

in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87927 ✓ 9 D 87927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Russell ST. Mt Wash WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack L. Dowell

(a) RESIDENCE No. 19 Russell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colr	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of x

6 DATE OF BIRTH (month, day, and year) Dec. 20-1923

7 AGE Years ~~1~~ Months 5 Days ~~28~~ If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Mt Winans
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph M Dowell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie E. Scott

13 BIRTHPLACE OF MOTHER (city or town) Mt Winans
(State or country)

14 Informant Joseph Dowell
(Address) Russell & Mt Winans

15 Filed ..... 19 Robert P. Harrison, Registrar

No 81924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-16, 1924, to 6-17, 1924,

that I last saw him alive on 6, 16, 1924,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. 5 weeks mos ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. Hall, M. D.

, 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 18 1924
20 UNDERTAKER	ADDRESS
Chas. H. Hooper	406 W. Lan

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87928 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1109 Brentwood Av St. 10 Ward) 128

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Nancy E. Reilly

(a) Residence No. 1109 Brentwood Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 29-1911

7-AGE, 12 yrs. 6 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... School Girl

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Jos G. Reilly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Annie E. McNeal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Annie E. Reilly

(Address) 1109 Brentwood Ave

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 16/1924

I HEREBY CERTIFY, That I attended deceased from March 26 1924, to June 16, 1924, that I last saw h[illegible] alive on June 16, 1924, and that death occurred, on the date stated above, at 7 m.

The CAUSE OF DEATH* was as follows:

Subacute Parenchymatous Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Iliac & Femoral Phlebitis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death? 719 E 21st St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) James M. Fenton M. D.

6-17, 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cem

DATE OF BURIAL, 6/19 1924

20-UNDERTAKER, H. C. Warfield

ADDRESS 914 Greenmount Av

UNT 8 192[illegible]

In plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important. [illegible] DISEASE EXACTLY. PHYSICIANS should state CAUSE OF

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87929

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87929

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

Registered No.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. John Reilly

(a) Residence No. Preston & Bailey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.)

5a-~~If married~~, widowed, ~~or divorced~~
HUSBAND of (or) ~~WIFE of~~ Dora Meader

6-DATE OF BIRTH (month, day and year) 17 March 1843

7-AGE, 81 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, George Reilly

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), x x

12-MAIDEN NAME OF MOTHER, x x

13-BIRTHPLACE OF MOTHER (city or town)..... x x (State or Country),

14-
(Informant) Sister Florence
(Address) Preston & Bailey

15-
Filed ....., 19.....
Registrar.

JUN 18 1924

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 17/24

17- I HEREBY CERTIFY, That I attended deceased from Home record
....., 19....., to....., 19.....,
that I last saw h.... alive on June 17, 19 24
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(Duration) ....yrs....mos. ....ds.

CONTRIBUTORY.....
(Secondary)

(Duration) ....yrs....mos....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

June 18, 19 24 (Signed) F. A. Warner, M. D.
(Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Dresden	June 19, 1924
20-UNDERTAKER.	ADDRESS
Jd. C. Wedefeld	914 Druid Pk

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
DO EXACTLY. PHYSICIANS should state CAUSE OF DEATH
instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87930 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 87930

Permanent dist at

CERTIFICATE OF DEATH. 188203

1-PLACE OF DEATH Johns Hopkins

CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Flynn

(a) RESIDENCE No 808 Albemarle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER John Flynn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Garvey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. John Kelly
(Address) 72 S Ellwood St Camden N.J.

15 Filed JUN 18 1924 192 Robert P. Harrison
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Autotruck Accident- Crushed cheat

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) P K Carter, M. D.
(Coroner.)

June 18/24 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	June 19 1924
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

IMPORTANT is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8793

CERTIFICATE OF DEATH.

D 8793

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., B WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Williams

(a) RESIDENCE NO 227 Herring Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 9-1916 unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Percy Co. (State or country) N.C.

PARENTS

10 NAME OF FATHER John Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Percy Co. N.C.

12 MAIDEN NAME OF MOTHER Cora Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Percy Co. N. C

14 Informant Cora Hughes Williams (Address) 227 Herring Ct

15 Filed 6 8 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Subacute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malria - Peritonitus

(duration) yrs mos. ds.

(Signed) J. S. Bacon, M. D. (Coroner.)

6/17/24 192 (Address) 508 E. north ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Percy Co N.C.	6/19 192 4
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Broad st

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87932

CERTIFICATE OF DEATH.

D 87932

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3722 Gough ST.: N WARD) 161-006

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Turowski

(a) RESIDENCE. NO. 3722 Gough ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alexander Turowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Cihon Grabczyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs P. Turowska (Address) 3722 Gough St

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

N 1 8 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 16, 1924, that I last saw him alive on June 16, 1924, and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Failure of vital centers to function (Atelectasis, etc)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature at 6 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brownshaz, M. D.

6-17, 1924 (Address) 3037 Edmondson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	6/18 1924
20 UNDERTAKER	ADDRESS
Wm Frankowski	618 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

should be stated EXACTLY. PHYSICIANS should sign

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87933

CERTIFICATE OF DEATH.

D 87933

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (NO. Balto. Md. ST., 4 WARD)

2-FULL NAME Mathais Gross

(a) RESIDENCE NO. York & Joppa Road, Towson, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? 10 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Deased

6 DATE OF BIRTH (month, day, and year) Feb. 12 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Maker. 084

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Paul. Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mathias Gross

(Address) 601 - York Road

15 JUN 1 9 1924 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17

I HEREBY CERTIFY, That I attended deceased from June 13, 1924, to June 18, 1924, that I last saw him alive on June 18, 1924, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

Chronic Nephritis

Uremia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path findings

(Signed) James F. White, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill	June 20 1924
20 UNDERTAKER	ADDRESS
J. Thos Burns Sons	Towson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D 87934

CERTIFICATE OF DEATH.

179 D 87934

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 46 W Biddle ST., 11 WARD)

2-FULL NAME Virginia Isabel Latrobe Cogswell

(a) RESIDENCE NO. 46 W Biddle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Andrew K. Cogswell

6 DATE OF BIRTH (month, day, and year) Jan 17 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	5	—	

8 OCCUPATION OF DEceased
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ..... do
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John H. B. Latrobe

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Virginia Mateley

13 BIRTHPLACE OF MOTHER (city or town) Mateley
(State or country) Miss

14 Informant Letitia Cogswell
(Address) 46 W Biddle St

15 JUN 1 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1924, to June 16th, 1924, that I last saw her alive on June 16th, 1924, and that death occurred, on the date stated above, at 10 00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Myocardial Degeneration

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sign & Symptoms

(Signed) J. A. Oldendorf, M. D.

June 17th, 1924 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 19 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Son Co	McCulloh & Orchard

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87935

3 D 87935

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 W. Hamburg ST. 21 WARD)

2-FULL NAME Marie Gross

(a) RESIDENCE NO. 412 W. Hamburg ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robt Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robt E Gross

(Address) 412 W Hamburg St.

JUN 19 1924

ROBERT R. KRAUTER,
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17/1924

17 I HEREBY CERTIFY, That I attended deceased from 5/27/, 1924, to 6/17/, 1924, that I last saw h... alive on 6/17/, 1924, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

Acute (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Remnent Bronchitis Acute (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lewis Bryden, M. D.

6/18/24, 19 (Address) 908 N Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	June 12 1924
20 UNDERTAKER	ADDRESS
I L Brown & Son	1310 W. Monty St

MATION should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be p
TION is very important. See instructions on back of c

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 1923 87936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 15 S. Glover St., 1 Ward)

Registered No. 90

2-FULL NAME John Henry Gaechsch

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

(a) Residence No. 15 Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbra Schaefer

6-DATE OF BIRTH (month, day and year): May 27 1854

7-AGE: 69 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Policeman 061

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Batt

PARENTS.

10-NAME OF FATHER: Theodor Gaechsch

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14- (Informant) Barbra Gaechsch

(Address) 15 Glover

15- JUN 19 1924 ROBERT B. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 18 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 19 23 to June 18 19 24

That I last saw h[illegible] alive on June 17 19 24

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Meyers Jr. M. D.

June 19, 19 24 (Address) 1638 E. Preston

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL, June 19 24

20-UNDERTAKER: Wendell Wyffel — ADDRESS 378 Penn

Fill in all items EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D 87937

CERTIFICATE OF DEATH.

D 87937

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No 2315 Inglederry St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Foley Humphreys

(a) Residence No 2315 Inglederry St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Baby

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 17-1924

7-AGE, ... yrs. 3 mos. 1 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore (State or Country), Md

PARENTS.

10-NAME OF FATHER, Maurice E. Humphreys

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Md

12-MAIDEN NAME OF MOTHER, Hilda Benny

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Md.

14- (Informant) Maurice E. Humphreys

(Address) 2315 Inglederry St.

15- Filed JUN 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-18-24

17- I HEREBY CERTIFY, That I attended deceased from 6-15-, 1924, to 6-18-, 1924, that I last saw him alive on 6-17-, 1924, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? pending

(Signed) Robert Reid Pughe M. D.

6-18-1924 (Address) 6 E Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, June 19, 1924

20-UNDERTAKER. Fred C. Miller ADDRESS 233 E. Fayette St.

IMPORTANT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87938

CERTIFICATE OF DEATH.

14 100 001

D 87938

REGISTERED NO. C

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1335 N Fremont Ave St.: (Ward)

2-FULL NAME Garfield Smith

(Residence in Baltimore: No. 1335 N Fremont Ave St.: yrs., 2 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (*Write* the word.) Single

6-DATE OF BIRTH, April 3rd, 1924
(Month) (Day) (Year)

7-AGE, ...yrs. 2 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), City

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (State or Country) S Carolina

12-MAIDEN NAME OF MOTHER Lula Morton

13-BIRTHPLACE OF MOTHER (State or Country), S Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Smith

(Address) 1335 N Fremont Ave

15- JUN 19 1924 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 19 1924 (Address) 2801 Eden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL June 19. 1924

20-UNDERTAKER Theresa E Wright ADDRESS 1364 Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state carefully all information should be carefully supplied.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

454 87939

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 209 N. Front st St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angelina Brocato.

(a) Residence No. 209 N. Front St. St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 7 mos. ds. How long in U. S., if of foreign birth? 26 yrs. 7 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) married

5a-If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Joseph Brocato.

6-DATE OF BIRTH (month, day and year) June 22/1879.

7-AGE. 44 yrs. 11 mos. 25 If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... 03
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Italy.

PARENTS.

10-NAME OF FATHER, Cosimo Angelucci.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Italy.

12-MAIDEN NAME OF MOTHER, Providenza Nulina

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Italy.

14-Informant) Joseph Brocato
(Address) 209 N. Front st.

15- JUN 19 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 17 1924

17- I HEREBY CERTIFY, That I attended deceased from April 1st 1924 to June 17 1924
that I last saw h. alive on June 17 1924
and that death occurred, on the date stated above, at 6.00 P.M.
The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Colon

(Duration) ....yrs. 10 mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of Aug 18, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture Streptococ

(Signed) Thomas J. Ruth M. D

, 19 (Address) 451-E. 22nd St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral Cemetery	June 20 1924
20-UNDERTAKER,	ADDRESS
Geo. J. Ruth	1735 Harford Ave

In plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87940

CERTIFICATE OF DEATH.

4 X 129

D 87940

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Harris

(a) RESIDENCE NO. Sykesville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of John Harris

6 DATE OF BIRTH (month, day, and year) ~~Jan~~ May 5th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Dr J. W. Steele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) University Hospital Dept

15 Filed JUN 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 19, 1924, that I last saw her alive on June 19, 1924, and that death occurred, on the date stated above, at 5:10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

probable (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis and chronic interstitial nephritis probable (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & symptoms

(Signed) John M. Edmonds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md	June 24

20 UNDERTAKER Jas. L. Reed ADDRESS Sykesville Md

▲ NATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

8794 D

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 8794

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia Smith

(a) Residence No. 421 Gymnasium Somerset Stut St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colred	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1854

7-AGE	If LESS than 1 day
70 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, Peter Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Martha Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records.

(Address)

15- JUN 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-15-24

17- I HEREBY CERTIFY, That I attended deceased from June 14 1924 to June 15 1924

that I last saw h.er alive on June 15 1924

and that death occurred, on the date stated above, at 11.-P. m.

The CAUSE OF DEATH* was as follows:

Bronchs - Pneumonia

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile Gangrene left foot with infection

(Duration) yrs. mos. 28 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D.

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, June 19 1924
20-UNDERTAKER	ADDRESS
Chas. H. Johnson	467 N. Caroline St.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. ed EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

D 87942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73

REGISTERED NO. D 87942

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Hebrew Home for Incurables ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Aron Welsh

(a) RESIDENCE NO. 2102 E Balto St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant H. Home of Incurables
(Address) E Balto st

JUN 9 1924

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1922, to June 18, 1924,
that I last saw h[illegible] alive on June 18, 1924,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Paralysis Agitans.

8 (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] M. D.
6/18, 1924 (Address) 190 Eaton Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	6/19 1924
20 UNDERTAKER	ADDRESS 1127
Sol Levinson & Bro	E Balto st

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 ✓ D 87943

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1221 Jefferson St ST., 5 WARD)

2-FULL NAME Frederick D. Jones

(a) RESIDENCE NO. 1221 Jefferson St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Jones

6 DATE OF BIRTH (month, day, and year) unknown 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER James Jones

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bannon

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Helen Jones (Address) 1221 Jefferson St

15 Filed JUN 7 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/24 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ruptured Appendical Abcess

(Pus in rt. quadrant abdomen)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mallon (Coroner.), M. D.

June 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge md	June 1924
20 UNDERTAKER	ADDRESS
Edward Bryan	1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Bks.

D 87944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87944

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Athol Terrace ST., From Frederick Road 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna E. Moore

(a) RESIDENCE NO. Athol Terrace ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 - 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	8	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alex. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Cecelia Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rose Nitsch

(Address) Athol Terrace

Filed JUN 19 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to June 17, 1924

that I last saw her alive on June 17, 1924

and that death occurred, on the date stated above, at 12. noon

The CAUSE OF DEATH* was as follows:

Senility Endocarditis

Arteriosclerosis

(duration) yrs. Nine mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. / mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Robert C. Nitsch, M. D.

6/19, 1924 (Address) 2151 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 20 1924
20 UNDERTAKER	ADDRESS
Chas. Fields	1200 W. Fayette

INFORMATION SHOULD be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87945

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 87945

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1730 N Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Georgiana F. Smith

(a) Residence No. 1730 N Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or ~~Divorced~~, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Smith

6-DATE OF BIRTH (month, day and year) June 12 1841

7-AGE, 83 yrs. 11 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country) Eastern Shore Md.

PARENTS.

10-NAME OF FATHER Robert Landis

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Eastern Shore Md.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Eastern Shore Md.

14- (Informant) Mrs. Georgiana F. Smith (Address) 1730 N. Lanvale St.

15- Filed JUN 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 18/24

17- I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 18, 1924, that I last saw h is alive on June 17, 1924, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Arteria - sclerosis - Myocarditis - and parenchymatous nephritis -

(Duration) 1 yrs. mos. ds.

Cerebral hemorrhage - and paralysis

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Riblett M. D.

June 18, 1924 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: 6-20, 1924

UNDERTAKER: Wilhelm Cadsie & Rentzan

ADDRESS

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.—400 Eks.

D 87946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87946

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1331 W 42nd St 13 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Boone

(a) Residence No. 1331 W 42nd St St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced~~ (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND (or) WIFE of Gideon B Boone

6-DATE OF BIRTH (month, day and year) July 27 1849

7-AGE. 74 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) ..... (State or Country) Md

PARENTS.

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Unknown

11- (Informant) Gertrude Boone

(Address) 1331 W 42nd St

15- FILED JUN 19 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 18 1924

17- I HEREBY CERTIFY, That I attended deceased from May 26 1924 to June 18 1924

that I last saw her alive on June 18 1924

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis & Endocarditis

Hypostatic Congestion

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 9 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation & Percussion

(Signed) Known Fuller M. D.

6/18 1924 (Address) 370 - Talbot Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Mary's Hanover DATE OF BURIAL. June 21, 1924

20-UNDERTAKER CHENOWETH & SON, ADDRESS 2017 CHESTNUT AVE

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87947

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87947

1-PLACE OF DEATH

City of BALTIMORE: (No. 1537 N. Bond St., 9 Ward) 90

Registered No.

2-FULL NAME Frances B. Booth

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1537 N. Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry A.

6-DATE OF BIRTH (month, day and year) Aug 10, 1842

7-AGE. 81 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of industry, business, or establishment in which employed (or employer). do

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER. James B. Harris

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Sarah C. Graves

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Lawrence R. Booth

(Address) 1537 N. Bond

15-

JUN 19 1924 ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-17-24

17- I HEREBY CERTIFY, That I attended deceased from 6-15, 1924 to 6-17, 1924

that I last saw h[illegible] alive on 6-17-24

and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & symptoms

(Signed) Daniel Miller M. D.

, 19 (Address) 500 Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore

DATE OF BURIAL, June 20 1924

20-UNDERTAKER. Zurhorst Zurhorst

ADDRESS 1739 Eager St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87948

CERTIFICATE OF DEATH.

17 D 87948

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 27 WARD)

2-FULL NAME John B. Yeager

(a) RESIDENCE NO 25 Woodlea Rd. (Overlea) WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?/? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Yeager

6 DATE OF BIRTH (month, day, and year) Nov 18/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	6	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER August Yeager

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Wagner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Elizabeth Yeager
(Address) 25 Woodlea Road

15 Filed JUN 19 1924 ROBERT F. KRAUTER,
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) n June 17/1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Terminal Bronchopneumonia
(Cut throat 5 days ago-Suicide)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pattison, M. D.
(Coroner.)

June 18/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	6/20 1924
20 UNDERTAKER Zirkin & Zirkin	ADDRESS 739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 87949 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Jackson

(a) RESIDENCE NO. Sollers P. O. Ann Arundle Co., Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgiana Jackson

6 DATE OF BIRTH (month, day, and year) June 9th 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) A. A. Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Kitty Brown

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co (State or country) Md

14 Informant Andrew Jackson

(Address) 1512 Eutaw Place

15 JUN 19 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18- 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-27- 1924, to 6-18- 1924, that I last saw h in alive on 6-14- 1924, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitis

From History Probably 6 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ann Arundle Co.

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) George C Page M. D.

, 19 (Address) 17 Pon. Mon. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch Cem	6/22 1924
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Mad st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87950

CERTIFICATE OF DEATH.

161-24 ✓ D 87950

1-PLACE OF DEATH

City of BALTIMORE: (No. 655 Light St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delizia De Gestino

(a) Residence No. 655 Light St., Ward

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. 4 How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-sEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) June 14-24

7-AGE. ..yrs. ..mos. 4 ds. If LESS than 1 day, ..hrs. or. ..min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Sam De Gestino

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Antonietta Libertini

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Sam De Gestino

(Address) 655 Light St

15- Filed JUN 19 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 18, 1924

17. I HEREBY CERTIFY, That I attended deceased from June 14 1924 to June 18 1924

that I last saw h~~e~~r alive on June 17 1924

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6½ Months)

.....(Duration).....yrs.....mos.....ds

CONTRIBUTORY.....

(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James H Kemp M. D

6/19, 1924 (Address) 1729 N Fremont Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Vincents	June 19 1924
20-UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Ave

In plain terms, so that it may be properly classified. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87951

CERTIFICATE OF DEATH.

46 D 87951

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1949 W. Mulberry St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Catherine Kelly

(a) Residence No. 1949 W. Mulberry St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm. Kelly

6-DATE OF BIRTH (month, day and year) Mar 30 1878

7-AGE, 45 yrs. 6 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Clerk

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Jesse Wagner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sarah Babylon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Elizabeth H. Staub

(Address) 1949 W. Mulberry

15- JUN 1 1924 ROBERT R. KRAUTER, Registrar,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 18, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 21, 1924, to June 18, 1924

that I last saw her alive on 6/17, 1924,

and that death occurred, on the date stated above, at 12.28 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & Appendages

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ovarian cyst,

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 7, 24

Was there an autopsy? No

What test confirmed diagnosis? Path. Exam

(Signed) [illegible], M. D.

6/18, 1924 (Address) 2020 W. Cleaves

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Meadow Branch, Balto Co. DATE OF BURIAL, June 20 1924

20-UNDERTAKER, W. M. Routson ADDRESS 2238 N. North

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D 87952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87952

CERTIFICATE OF DEATH.

185

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine O'Neill

(a) RESIDENCE NO. 337 S. Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29, 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Dwyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records (Address)

15 Filed JUN 19 1924, 19 Robert P. Harrison, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 24, to June 18, 19 24, that I last saw her alive on June 18, 19 24, and that death occurred, on the date stated above, at 9.25 p m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Senility

Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 6/15/24

Was there an autopsy?

What test confirmed diagnosis? Clinical data

(Signed) Dr. A. F. Rittenhouse, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral bon	June 21 1924
20 UNDERTAKER J. G. Moran	ADDRESS 200 E. Balto St.

INFORMATION SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will please state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87953

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1014 Fillmore ST. 24 WARD)

REGISTERED NO. 74001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas McCormick

(a) RESIDENCE. No. 1014 Fillmore ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1834

7 AGE — Years: 90 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Galway Ireland

PARENTS

10 NAME OF FATHER: Thomas McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Galway Ireland

12 MAIDEN NAME OF MOTHER: Bridget Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Galway Ireland

14 Informant: — Michael Riordan

(Address): — 2208 Parkhill

15 Filed June 18 1924 . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) — June 17 1924

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1924, to — June 17, 1924, that I last saw h alive on June 17, 1924, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 wk ds.

CONTRIBUTORY (Secondary) — Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

6/18, 1924 (Address) 1211 Fillmore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jews Cathedral Cem	June 20 1924
20 UNDERTAKER	ADDRESS
J. A. Moran	300 E Balto St

Fold

Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be of use to the Clerk of certificates. See instructions on back of CERTIFICATION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87954

CERTIFICATE OF DEATH.

46

D 87954

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST., 24 WARD)

2-FULL NAME Mrs. Sadie Mencshaw

(a) RESIDENCE NO. 1645 Covington ST ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 2 mos. 30 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	W'd.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 19- 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	46	2	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pollo
(State or country)

PARENTS

10 NAME OF FATHER Jno H Talbott

11 BIRTHPLACE OF FATHER (city or town) Pollo
(State or country)

12 MAIDEN NAME OF MOTHER Millie Lankenau

13 BIRTHPLACE OF MOTHER (city or town) Pollo
(State or country)

14 Informant Sadie M. Mencshaw
(Address) 1645 Covington St

15 Filed 1924 Robert P. Harrison,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.18.1924

17 I HEREBY CERTIFY, That I attended deceased from 5.30.24, to 6.18.1924.

that I last saw h— alive on 6.18.24, 19....;

and that death occurred, on the date stated above, at 12 00 pm.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

Carcinoma 1

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Surgical Shock,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 6-18-24

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Evid.

(Signed) Jno A Dennis Jno M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 21 1924
20 UNDERTAKER John Cook	ADDRESS 502 E Hillsave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 87955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Brewer ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Nunn

(a) RESIDENCE NO. 1107 Brewer St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip Nunn

6 DATE OF BIRTH (month, day, and year) about 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Fannie Johnson
(Address) 1107 Brewer St.

15 JUN 19 1924 Robert P. Harrison, Registrar
Deputy Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

(Signed) C. J. Hemerson, M. D.
(Coroner.)

June 15, 1924 (Address) 2802 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 20 1924
20 UNDERTAKER	ADDRESS
Mrs Ida Snowden	1225 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87956

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87956

135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. H. Carpenter

(a) RESIDENCE NO. 1229 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Annie Carpentier

6 DATE OF BIRTH (month, day, and year) June 24/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butler 070
(b) General nature of industry, business, or establishment in which employed (or employer) Private Family
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Carpenter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Summer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Raymond Carpenter (son)
(Address) 129 Druid HillAve

15 Filed JUN 19 1924 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Uremia-retention-benign tumor prostate gland
(Autopsy at Hopkins)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. L. Kolb, M. D.
(Coroner.)
6/18/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 20, 192 24

20 UNDERTAKER J. M. Johnson — ADDRESS 1229 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 87957

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924-007 D 87957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Chlan

(a) RESIDENCE No. 708 N. Bradford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: RubberTire-worker
(b) General nature of industry, business, or establishment in which employed (or employer): 086
(c) Name of employer: Lion Tire & Rubber Co

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Charles Chlan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Frances xxxxx

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Mary Jindra (Aunt)
(Address) 708 N. Bradford St

15 Filed JUN 19 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Infection - Traumatism to right arm by machinery while at work- Accidental

May 15/24 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Patterson, M. D. (Coroner.)

June 17/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 20 1924

20 UNDERTAKER: Frank E. Brockbank Son — ADDRESS: 1906 Eastern Ave

TION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Bks.

D 87958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87958

CERTIFICATE OF DEATH.

94

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 15 WARD)

2-FULL NAME Charles Hamm Mettee

(a) RESIDENCE NO. Wilson Hills ST., Baltimore WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Carroll Mettee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Marian Hamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Carroll R. Mettee
(Address) 2 Queen Anne Rd.

15 Filed Robert P. Harrison, Registrar

N 1 91924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 18, 1924,

that I last saw he alive on June 18, 1924,

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus.

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Operation for Tonsils & Adenoids (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 18, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Path. Diagnosis

Signed Coroner J. J. Morrison M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL June 20 1924

20 UNDERTAKER Wm. J. Ruckert & Sons

ADDRESS Northern Pkwy

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec- 12-23-21—E.B.R.S.—400 Blks.

D 87959

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-08 D 87959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 827 N. Montford Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Thomas A. Davis

(a) Residence No. 827 N. Montford Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Davis

6-DATE OF BIRTH (month, day and year): April 14 1867

7-AGE. 57 yrs. 2 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Webster Car Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Thomas Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

11- (Informant) Mrs. Mary E. Davis

(Address) 827 N. Montford Ave.

13- JUN 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 17 1924

17- I HEREBY CERTIFY, That I attended deceased from June 12 19 24 to June 17 19 24

that I last saw h[illegible] alive on June 17 19 24

and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Tabes Pneumonia

(Duration) ....yrs. 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Samuel A. Cohn M. D

19 24 (Address) 802 S Patterson Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cemetery

DATE OF BURIAL: June 20 19 24

20-UNDERTAKER: H. Sander & Sons

ADDRESS: 1710 Fleet St.

EXACTLY. PHYSICIANS should state CAUSE OF DEATH Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Examples of insufficient statements and proper statements are given instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87960

CERTIFICATE OF DEATH.

11 Ward D 87960

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 Mc Mechen St.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence A Ford

(Residence in Baltimore: No. 546 Mc Mechen St.; yrs. 42 mos. 4 ds. 3)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Feb 14, 1882 (Month) (Day) (Year)

7-AGE, 42 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE. (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Geo Davis

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Ford

(Address) 546 Mc Mechen St

15- JUN 20 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6-17-24, 191... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6-6-1924, to 6-17-1924 that I saw h[er] alive on 6-17-24 91, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Toxic Gastritis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Bad teeth and Pus Tonsils about 30 days

(Duration) yrs. mos.

(Signed) Wm R Boyston M. D.

6/18, 191 4 (Address) 1618 Calhoun

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery DATE OF BURIAL, June 20, 191 4

20-UNDERTAKER Franklin W Seitz ADDRESS 709 W 33rd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D 87961 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 87961

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 Power St ST., 13 WARD)

2-FULL NAME Charles C. Thomas

(a) RESIDENCE NO. 804 Power St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Sarah L. Thomas

6 DATE OF BIRTH (month, day, and year) July 11 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	72	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Zink

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ezekiel Not Known

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Ezekiel Not Known

14 Informant Mellord Thomas

(Address) 804 Power St

JUN 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 18, 1924.

that I last saw him alive on June 18, 1924,

and that death occurred, on the date stated above, at 4-20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

6/14, 1924 (Address) 3429 Cleveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cemetery H. | DATE OF BURIAL June 20, 24

20 UNDERTAKER R S Marshall | ADDRESS 3539 Falls Rd

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87962

CERTIFICATE OF DEATH.

8 D 87962

REGISTERED NO.

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Thompson

(a) RESIDENCE No 1619 Ensor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of nnnnnn

6 DATE OF BIRTH (month, day, and year) Dec 29/1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John J. Thompson

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Herbert

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant John J. Thompson
(Address) 1619 ENsor St.

15 JUN 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Scarletinal Nephritis

Autopsy at Hopkins

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) J. S. H. Ballen, M. D.
(Coroner.)

June 19/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mns., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Govaudons.	June. 20 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	1301 E Eager St

TION is very important. See instructions on back of certificate. ay be properly classified. Exact statement of OCCUPA- terms, so that it may be PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D 87963

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 B 01 87963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Severn Apt

CITY OF BALTIMORE: (No. Cathedral & Monument ST. 811 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Pegram

(a) RESIDENCE No. Cathedral & Monument ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~ Widowed, or Divorced. (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Late William Mead Pegram

6 DATE OF BIRTH (month, day, and year) December 19 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis W Aldrick

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. H. Elderdice

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Miss Pegram

(Address) Baltimore Md

JUN 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1924

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 1924, to 6/18, 1924, that I last saw h[illegible] alive on 6/18, 1924, and that death occurred, on the date stated above, at 10.15 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial disease

(duration) yrs. 6 mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

19 [illegible], 1924 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 21 1924

20 UNDERTAKER Henry W Jenkins & Sons Co ADDRESS Orchard & Calhoun St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Edward Lee · Rickards

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87964

CERTIFICATE OF DEATH.

162

D 87964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1509 William ST., 24 WARD)

2-FULL NAME Edward Lee Rickards

(a) RESIDENCE NO. 1509 William ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. Fifteen ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eng

6 DATE OF BIRTH (month, day, and year) June 22, 1924

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
15 Minutes	9th Fortal month		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Lee Rickards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Pleasant R. Maudy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London Co Va

14 Informant Mrs Pleasant Rickards

(Address) 1509 William St

15 JUN 20 1924 ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 20 - 1924.

17 I HEREBY CERTIFY, That I attended deceased from 6.20, 1924, to 6.20, 1924, that I last saw h.. alive on 6.20, 1924, and that death occurred, on the date stated above, at 6.35 a m.

The CAUSE OF DEATH* was as follows:

Dyspneia

(duration) yrs. 3 hrs mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. J. Burlington, M. D.

6-24 1924 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. Frederick — DATE OF BURIAL June 20 1924

20 UNDERTAKER C. Howard Evans — ADDRESS 358 Fort Ave

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87965

X 101-001

D 87965

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 S Hanover ST., 22 WARD)

2-FULL NAME Conrad Edwards

(a) RESIDENCE NO. 811 S. Hanover ST., 22 WARD 22

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. 11 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Dockyard

(c) Name of employer Am Sugar Refining

9 BIRTHPLACE (city or town) (State or country) Jamaica B.W.I.

PARENTS

10 NAME OF FATHER Josiah Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica, B.W.I.

12 MAIDEN NAME OF MOTHER Eliza Monroe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica B.W.I.

14 Informant James Edwards

(Address) 112 W. Hamilla St.

15 JUN 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 19 24

17 I HEREBY CERTIFY, That I attended deceased from June 13 19 24 to June 18 19 24

that I last saw h alive on June 18 19 24

and that death occurred, on the date stated above, at 12:00 P m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchitis Acute

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Ernest Bowley M. D.

19 (Address) 908 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 20 1924
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87966 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87966

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 635 N. Kenwood ave., Ward) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Margaret Finn

(a) Residence No. 635 N. Kenwood ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James L Finnie

6-DATE OF BIRTH (month, day and year) Jan 3rd 1861

7-AGE.	If LESS than 1 day,
63 yrs. 5 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant)..... Margaret Finn

(Address) 402 N. Stricker St

15-

Filed ..... 192 ROBERT R. KRAUTER, Registrar.

JUN 20 1924 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-18-24

17- I HEREBY CERTIFY, That I attended deceased from 6-15 19..... to 6-18 19 24

that I last saw him alive on 6-18 19 24

and that death occurred, on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Diffuse Glomerulo Nephritis

Diphtheria, Pneumonia

(Duration) 1 mos. ds.

CONTRIBUTORY (Secondary) acute Edema of Lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Reinhardt M. D.

6-19-24 (Address) 600 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem	June 21, 1924

20-UNDERTAKER. ADDRESS

Wm F. Hartley 815 N. Washington St

In plain terms; so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 87967.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 87967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Cedar Av. Walbrook ST. 25 WARD)

2-FULL NAME Vernon Wm Rockenfuss

(a) RESIDENCE NO. 231 Cedar Av. Walbrook ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	WHI	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25/1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	5		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Edw. J. Rockenfuss

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Cath. E. Ryan

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Mrs E. Rockenfuss
(Address) 231 Cedar Av Walbrook

15 JUN 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1924

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1924, to June 19, 1924,

that I last saw h[illegible] alive on ..., 19...

and that death occurred, on the date stated above, at 12-15 a m.

The CAUSE OF DEATH* was as follows:

Heart failure due to
Fever following fall
from ladder by Accd

(duration) ... yrs. ... mos. One ds.

CONTRIBUTORY (Secondary) Likely Injury to Brain

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. A. Smith, M. D.

6/19, 1924 (Address) 1005 N North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Violetville Md	6/22/24
20 UNDERTAKER	ADDRESS
Gr. Weber & Son	2503 Edmondson Ave

INFORMATION, WRITTEN IN UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.H.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87968

CERTIFICATE OF DEATH.

91-002

D 87968

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 920 Poplar Grove St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elizabeth E. Bradford

(a) Residence No..... 920 Poplar Grove St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William Bradford

6-DATE OF BIRTH (month, day and year) Apr. 5, 1850

7-AGE.	If LESS than 1 day,
74 yrs. 1 mos. 12 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

(c) Name of employer.....

9-BIRTHPLACE (city or town)... Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob F. Corns

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Martha Walters

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany

14- (Informant). Mrs. C. Stump

(Address). 920 Poplar Grove Street

15- Filed JUN 20 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 1, 19 24, to June 17, 19 24

that I last saw her alive on June 17, 19 24

and that death occurred, on the date stated above, at 3.15 P.m.

The CAUSE OF DEATH* was as follows:

General Sclerosis
Sahlerosis, Oedema
of Lungs
(Duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (Duration) ✓ yrs. ✓ mos. ✓ ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John A. Bratand M. D.

6 18-1924 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Loudon Park	June 20, 1924
20-UNDERTAKER.	ADDRESS
Jas. Block	1003 W Baltimore

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87969

66D 87969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — CITY OF BALTIMORE: (No. Pronounce d dead at S St. Joseph Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Colb ert

(a) RESIDENCE No. 917 Shutter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Can-packer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: W.W.Boyer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs Elliott
(Address): 1915 Ashland Ave

15 Filed JUN 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14/24 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) [signature] (Coroner.), M. D.

June 19/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: June 20 92 y

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS: 1915 Ashland Ave

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87970 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87970

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2921 Hudson St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Magdelena Helbing

(a) Residence No. 2921 Hudson St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Helbing

6-DATE OF BIRTH (month, day and year) Aug 11/48

7-AGE. 75 yrs. 10 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Spindler

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14- (Informant) John W. Helbing

(Address) 2921 Hudson

15- ROBERT R. KRAUTER, Burial Permit Clerk.

JUN 20 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/18/24

17- I HEREBY CERTIFY, That I attended deceased from Jan 16th 1924 to June 17th 1924

that I last saw h.er alive on June 17th 1924

and that death occurred, on the date stated above, at 1.01 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Robert L. Kerk M. D

6/19, 1924 (Address) 3126 Harford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Mathews	6/20 1924
20-UNDERTAKER. Philip Herwig	ADDRESS 2016 Aisquith

in plain terms, so that it may be properly classified. instructions on back of certificates.

...ed EXACTLY. PHYSICIANS should state CAUSE OF DEATH ...ed. Exact statement of OCCUPATION is very important. See ...ssary supplied. AGE should be stated

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87971

CERTIFICATE OF DEATH.

118-002

D 87971

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 W Fayette ST., 19 WARD)

2-FULL NAME Mary Wynne

(a) RESIDENCE NO. 1714 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Wynne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James Wynne

(Address) 1959 W Fayette St

15 Filed JUN 26 1924 ROBERT J. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1924

17

I HEREBY CERTIFY, That I attended deceased from January 12, 1919, to June 19, 1924, that I last saw her alive on June 19, 1924, and that death occurred, on the date stated above, at 3. a m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction - 1 day
Chronic Myocarditis 5 yr.
Arteriosclerosis 5 yr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma 1

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Mcnamara M. D.

(Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/21/24
20 UNDERTAKER George A Farley Fulton	ADDRESS Fayette st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Sarah A. Shepherd. 6/1002

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87972

CERTIFICATE OF DEATH.

143 D 87972

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mercy Hospital St., 15 WARD)

2-FULL NAME Mrs Sadie Shepherd.

(a) RESIDENCE No. 2437 Walbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Shepherd.

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife. 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Dave McSweeny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Oliver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record (Address)

15 Filed JUN 20 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18/24

17 I HEREBY CERTIFY, That I attended deceased from 6/12/24, 19..., to 6/18/24.

that I last saw h... alive on 6/18/24, 19...

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema, Pneumonia, Bronchial

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Presbyterian Hospital

Did an operation precede death? No Date of 6/14/24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) K. V. Godley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 6/21/24

20 UNDERTAKER Frank Speer

ADDRESS 1600 N Eutaw Ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87973

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Allmutt

(a) RESIDENCE NO. Gaithersburg Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ben Allmutt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mrs. Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Roy Barker

(Address) Taylorsville Md

15 Filed 1924, 19 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1924, to June 20, 1924,

that I last saw him alive on June 20, 1924,

and that death occurred, on the date stated above, at 2:27 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis & arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sign & symptom

(Signed) W. P. Dodd, M.D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Taylorsville Cem	June 22 1924
20 UNDERTAKER Easton Sons	ADDRESS Elliott City

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87974 ✓ D 87974

D 87974

CERTIFICATE OF DEATH.

Registered No. 45

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 Shields alley St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Mason

(a) Residence No. 1427 Shields alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE Colored

5-Single, ~~Married,~~ Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar 8 1891 unknown

7-AGE, 33 yrs. 3 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). Ice Plant

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, Chas Mason

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Frank Mason

(Address) 1427 Shields Alley

15- Filed JUN 20 1924, 19?

DUBLIN K. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 17, 1924

17- I HEREBY CERTIFY, That I attended deceased from April 15, 19 24 to June 17, 19 24

that I last saw him alive on June 17, 19 24

and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Peritoneal Carcinomata

(Duration) yrs. 4 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? H. S. M. Card

(Signed) H. S. M. Card, M. D.

6/18, 19 24 (Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park | DATE OF BURIAL, June 17, 1924

20-UNDERTAKER, Samuel Greenberg | ADDRESS, W. Baltimore

In plain terms, so that it may be properly classified. Every item of information requested EXACTLY. PHYSICIANS should state CAUSE OF DEATH instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87975

CERTIFICATE OF DEATH.

38 D 87975

1-PLACE OF DEATH Bay View Hospital. Registered No.....

City of BALTIMORE: (No.....St., 27.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jonas Johnson

(a) Residence No. 119 Ridgely St. St., ...Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Blk.	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6-DATE OF BIRTH (month, day and year) 1889.

7-AGE.	If LESS than 1 day,
35 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer. old

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown.
(State or Country),

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town) Do.
(State or Country), Do

14- (Informant) Bay View Hospital.

(Address) Eastern Ave.

15- JUN 20 1924 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/17/24.

17- I HEREBY CERTIFY, That I attended deceased from May 19, 1924 to June 16, 1924 that I last saw him alive on June 16, 1924 and that death occurred, on the date stated above, at 4.30A. on.

The CAUSE OF DEATH* was as follows:

General Paralysis

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Luetic Infection

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical and serological findings

(Signed) Claude A. Drane M. D.

6-12-1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cem	June 20, 1924
20-UNDERTAKER.	ADDRESS.
Samuel Stanley	1 N Bid Balto

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87976

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1831 N. Durham St., 8 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.....Eugene C. Moseley

(a) Residence No. 1831 N. Durham St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Barbara Moseley

6-DATE OF BIRTH (month, day and year) Sept 3 1859

7-AGE, 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)..... 07

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Boston Mass

PARENTS.

10-NAME OF FATHER David C Moseley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Boston Mass

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Boston Mass

14- (Informant) Barbara Moseley

(Address) 1831 N. Durham st

15- Filed....., 192.....

ROBERT R. KRAUTER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 17-1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 15, 1923 to June 17, 1924

that I last saw him alive on June 17, 1924

and that death occurred, on the date stated above, at 3.08 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Colon

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm J Watson, M. D.

June 19, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cemetery — DATE OF BURIAL, June 20 1924

20-UNDERTAKER, Chas O Zimmerman Inc — ADDRESS 1424 W. Baltimore

In filling out this certificate, PENCIL should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-20-21—E.B.R.S.—400 Bks.

D 87977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 | 29

D 87977

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 423 N. Luzerne Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ANNE E. SLATTERY.

(a) Residence No. 423 N. Luzerne Ave. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Florance W. Slattery

6-DATE OF BIRTH (month, day and year) Unknown 1857

7-AGE. 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Sclann

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ireland

14- (Informant) Miss Slattery

(Address) 423 N. Luzerne Ave.

15- JUN 20 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 18 1924.

17- I HEREBY CERTIFY, That I attended deceased from May 8 – 24, 19..... to June 18, 19 24

that I last saw h[illegible] alive on 17 19 24

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chron. Par. Nephritis

6

(Duration) ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary) Coma

(Duration) ..... yrs. ..... mos. 2 ds

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? ..... Wh[illegible]

What test confirmed diagnosis? Physical Signs

6/19/24 (Signed) Chas. A. Neil M. D.

(Address) 4085 Pat Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery.	June 21 1924
20-UNDERTAKER.	**ADDRESS**
Chas F. Evans & Son	118 W. Mt. Royal Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wisnieuski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87978

87978

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S. Ann ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Wisnieuski

(a) RESIDENCE NO. 416 S. Ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Wisnieuski

6 DATE OF BIRTH (month, day, and year) June 17 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER V. Wisnieuski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant F. Wisnieuski

(Address) 416 S. Ann St

15 JUN 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17 I HEREBY CERTIFY, That I attended deceased from May, 1924, to June 18, 1924, that I last saw h[illegible] alive on June 14, 1924, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation 1 day

Cardiac Decompensation one month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy and Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) A F Reis, M. D.

June 20 1924 (Address) 24 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL June 21 1924

20 UNDERTAKER F. V. Ozarowski ADDRESS 1930 Eastern Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 87979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D 87979

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3040 Boston ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Kazaarska

(a) RESIDENCE. No. 3040 Boston ST., 1 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 18 - 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. Wife

(b) General nature of industry, business, or establishment in which employed (or employer) H. Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Frank Kaniecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Susie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaus Karczoski

(Address) 3040 Boston St

15 JUN 20 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1924

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1924, to June 18, 1924, that I last saw her alive on June 18, 1924, and that death occurred, on the date stated above, at 2 a 1 m.

The CAUSE OF DEATH* was as follows:

Cerebral abscess, following mastoiditis, chronic

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) O. B. Bronshaw M. D

6-19, 1924 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	June 21 1924
20 UNDERTAKER	ADDRESS
Stephen J Fiaskowski	1000 Hanover

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– E.B.R.S.—400 Bks.

D 87980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 87980

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 124 Aisquith St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calman Greenberg

(a) Residence No. 124 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Greenberg

6-DATE OF BIRTH (month, day and year)

7-AGE. 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Fish Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14- (Informant): J. Lewis

(Address): 1439 E. Balto.

15- JUN 2 0 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 20-24

17- I HEREBY CERTIFY, That I attended deceased from June 4th 19 23 to June 20 19 24.

that I last saw h. alive on June 19 19 24.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanition

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Elmer B Freeman M. D.

. 19 (Address) 412 Cathedral St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Rosedale — DATE OF BURIAL: June 20, 19 24

20-UNDERTAKER: Jno T Lewis — ADDRESS 1439 E Balto

EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87981

CERTIFICATE OF DEATH.

118 D 87981

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 21 WARD)

2-FULL NAME Patrick A Brien

(a) RESIDENCE NO. 923 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Cleary O'Brien

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Molder

(b) General nature of industry, business, or establishment in which employed (or employer) 047

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Furlong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant St Josephs Hospital (Address)

15 Filed . 19 ROBERT R. KRAUTER, Registrar

JUN 20 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-15, 1924, to 6-19, 1924,

that I last saw him alive on 6-19, 1924,

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction due

To Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-17-24

Was there an autopsy? no

What test confirmed diagnosis? Operative & Clinical findings

(Signed) J. Norwood Wilson M. D.

. 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 23 1924
20 UNDERTAKER	ADDRESS
J Lee & Edward Lee	901 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 87982 — 161-09 — D 87982

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 921 Hadlow St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Catherine M. Seifert

(a) Residence No. 921 Hadlow St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) June 11 - 1852

7-AGE,	If LESS than 1 day,
....yrs....mos....ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None, HW

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore Md
(State or Country),

PARENTS.

10-NAME OF FATHER Henry L. Seifert

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country),

12-MAIDEN NAME OF MOTHER Catherine E. Noll

13-BIRTHPLACE OF MOTHER (city or town)..... Md
(State or Country),

14- (Informant) Mr. Henry L. Seifert

(Address) 921 Hadlow St.

15- Filed JUN 20 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 19th 1924

17- I HEREBY CERTIFY, That I attended deceased from 6/11/24 19.... to 6/19/24 19....

that I last saw h.. alive on 6/19/24 19....

and that death occurred, on the date stated above, at 1. P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (1 Mo.) (Acute)

Enteritis

.....

.....(Duration)....yrs....mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (terminal)

.....(Duration)....yrs....mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms, post mortem etc.

(Signed) E. M. Seifert, M. D.

6/20/, 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Olivet Cem.	June 21st 1924
20-UNDERTAKER	ADDRESS
J. F. Bowman Co.	Baltimore Md

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87983 CERTIFICATE OF DEATH. 161 001 ✓ D 87983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 Washington Blvd St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Williams

(a) RESIDENCE NO. 635 Washington Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19, 1924

7 AGE	Years	Months	Days	If LESS than 1 day 8/24 hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Joseph Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Ruby Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant mother

(Address)

JUN 20 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to June 19, 1924, that I last saw her alive on June 19, 1924, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity -

(28 week foetus)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris Leon, M. D.

6/17 1924 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

JUN 19 1924

Baltimore Health Department

FOR INFORMATION AND CAUTION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87984

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D 87984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Vincent St. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elinor Smith

(a) RESIDENCE NO. 1116 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mason Smith

6 DATE OF BIRTH (month, day, and year) May 14, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER John Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Granberry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Mason Smith
(Address) 1116 Vincent St.

15 Filed JUN 21 1924, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) no history (over)

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

June 19, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 21 1924
20 UNDERTAKER Jesse Tedder	ADDRESS 436 Biddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 87985 HEALTH DEPARTMENT—CITY OF BALTIMORE D 87985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1404 Mt Royal Ave St., 14 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angie Margaret Staig

(a) Residence No. 1404 Mt. Royal Ave St., 14 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? 68 yrs. 4 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Feb 14-1856

7-AGE. 68 yrs. 4 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, George W. Staig

11-BIRTHPLACE OF FATHER (city or town) (State or Country), London England

12-MAIDEN NAME OF MOTHER, Kate Proudfoot

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Maryland

14- (Informant) Mr Jas M. Staig (Bro.)

(Address) 1404 Mt Royal Ave.

15- Robert P. Harrison, 192.... Registrar.

N2 01924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19-24

17- I HEREBY CERTIFY, That I attended deceased from April, 1924, to June 19, 1924, that I last saw her alive on June 19, 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

About 3 months (Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

.....(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. K. Pomeroy, M. D.

June 19, 1924 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Greenmount Cemetery — DATE OF BURIAL. June 21, 1924.

20-UNDERTAKER. STEWART & HOWER COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS s in plain terms, so that it may be properly classified. Exact statement of OCCUI instructions on back of certificates.

Spec. 1 10 21 MAT 1500 Blks.

D. 87986 Pettey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 87986

CERTIFICATE OF DEATH.

179

1-PLACE OF DEATH Don Seamus Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Dayton ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Harry J. Pettey

(a) RESIDENCE NO. 4120 Fernhill Ave. ST., WARD W. Arlington

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jane Frances Pettey

6 DATE OF BIRTH (month, day, and year) Dec 19 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	69	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 109

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Pettey

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Harry J. Pettey

(Address) 4120 Fernhill Ave

15 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/24 19

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 19, 1924,

that I last saw him alive on June 19, 1924,

and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. + mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Clin. & Lab. Tests.

(Signed) Hugh Odell, M. D.

6/19/1924 (Address) Don Seamus Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 23 19 24
20 UNDERTAKER	ADDRESS
Harry R. Annacott	4204 Ridgewood Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 87987

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87987

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 W Hamburg ST. 21 WARD)

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Catherine Pelt

(a) RESIDENCE. No. 609 W Hamburg ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Pelt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Minnie Jacob.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Louis Pelt

(Address) 609 W. Hamburg st

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

N2 01924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 24

17 I HEREBY CERTIFY, That I attended deceased from June 16th 1924 to June 20th 24

that I last saw her alive on June 19th 24

and that death occurred, on the date stated above at 10A. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Whooping Cough & Congestion

debility (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Poulton, M. D.

6/20 1924 (Address) 3907 Gunston Block

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 21st 1924
20 UNDERTAKER	ADDRESS
E. Sahlsman & Son	Baltimore

BEFORE THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN'S should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

P 37988 13 — D 87988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Cale

(a) RESIDENCE NO. Hudson, W. Va. ST., ... WARD D

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret Cale

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Israel Cale

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1924 to June 19, 1924, that I last saw h alive on June 19, 1924 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 3 1 24

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) ..... M. D.

, 19 (Address) J. H. Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Terra Alta W Va	June 20 24
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Busy

JUN 20 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87989

172539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87989

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 26 WARD)

2-FULL NAME Albert Charles

(a) RESIDENCE NO. 2038 6th St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 13 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Catherine Daniels

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 20 1924 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 7 1924, to June 20 1924, that I last saw him alive on June 20, 1924, and that death occurred, on the date stated above, at 6.50 p. m.

The CAUSE OF DEATH* was as follows:

Acute primary pneumonia (lobar)

(duration) ... yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) ... yrs. ... mos. 13 ds. +

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 7

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. A. Wreach M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 21 1924
20 UNDERTAKER Wm. F. Galbraith & Son	ADDRESS 1618 Eastern Ave.

N2 01924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should also CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 87990

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87990

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 E. Barney ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Jenkins

(a) RESIDENCE NO. 28 E. Barney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert F. Jenkins

6 DATE OF BIRTH (month, day, and year) Apr 20, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Hockenbrodt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Katherine Haberkam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert F. Jenkins

(Address) 28 E. Barney St

15 Robert P. Harrison, Registrar

Burial Permit Clerk

N2 0 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924.

17 I HEREBY CERTIFY, That I attended deceased from May 3 1923, 19..., to June 18, 1924.

that I last saw her alive on June 18, 1924.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) — Rheumatism Arthritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Fields M. D.

6/7, 1924 (Address) 1277 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	June 21 1924.
20 UNDERTAKER	ADDRESS
Mr Mrs Jno W Teufel & Son	808 W. Fayette

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8799F

D 8799F

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 Radecke Ave, ST., Gardenville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine N. Sohn

(a) RESIDENCE No. 303 Radecke Ave. ST., Gardenville WARD 26

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER John T. Sohn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Spears

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant John G. Klein

(Address) Magnolia Md.

N2 1924 Robert F. Harrison, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17

I HEREBY CERTIFY, That I attended deceased from March, 1923, to June 18, 1924, that I last saw her alive on June 18, 1924; and that death occurred, on the date stated above, at 11:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Fibroid Tuberculosis

(duration) 60 yrs. (?) mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

6/19/1924 (Address) Reisterstown, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 21-24
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D 87992

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87992

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5622 Evergreen Ave. ST., Overlea WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Harver

(a) RESIDENCE No. 5622 Evergreen Ave. ST., Overlea WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina E. Harver

6 DATE OF BIRTH (month, day, and year) Dec. 14th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1/6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Harver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Horace Harver

(Address) Overlea Md.

15 Filed JUN 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1924, to June 19, 1924, that I last saw h[illegible] alive on June 16, 1924, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Harriman M. D.

6/20 1924 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kreider Lutheran Cemetery Gastonia	June 22 24
20 UNDERTAKER	ADDRESS
Fredk Loose & Sons	Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87993

D. 87993

CERTIFICATE OF DEATH.

78

D 87993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Jones

(a) RESIDENCE NO. 806 Pennsylvania ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rosalie Jones (?)

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1885?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38.	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 10

(b) General nature of industry, business, or establishment in which employed (or employer) Waiter.

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Geo. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Kate Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tennessee

14 Informant (Address) Hospital Record

15 Filed N 2 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/1924

17 I HEREBY CERTIFY, That I attended deceased from 6/17/24, 19..., to 6/20/24, 19..., that I last saw him alive on 6/20/24, 19..., and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Epilepsy

Chr. Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholic Gastritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Gelbach, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	June 21, 1924
20 UNDERTAKER	ADDRESS
Edw. Cook	502 E. Monts

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87994

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Franklin Square Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Mary E. Key

(a) Residence No. 3508 Powhattan Avenue St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Key

6-DATE OF BIRTH (month, day and year) Mar. 19, 1864

7-AGE.	If LESS than 1 day,
60 yrs. 3 mos. 0 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore, (State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Frederick Locke

11-BIRTHPLACE OF FATHER (city or town) Baltimore, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Laura Wolfe

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country) Maryland

14- (Informant) Mrs. E.H. Burrows

(Address) 2606 Elsinor Avenue

15- FILED JUN 21 1924, 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to June 18, 1924

that I last saw her alive on June 14, 1924

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death? 3402 Lanvale

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis Surgical & pathological findings

(Signed) Chas. A. Cox M. D.

6-19-24 (Address) 2406 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park Cem	June 21, 1924
20-UNDERTAKER,	ADDRESS
Joseph B Cook	1003 N Eutaw

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87995

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87995

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2666 Lehman Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Amos Sanders

(a) Residence No. 2666 Lehman Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Sanders

6-DATE OF BIRTH (month, day and year) Oct. 24, 1850

7-AGE, 73 yrs. 7 mos. 27 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer): for self

(c) Name of employer:

9-BIRTHPLACE (city or town) Washington, (State or Country), D C.

PARENTS.

10-NAME OF FATHER, James Sanders

11-BIRTHPLACE OF FATHER (city or town) Prince George Co. (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Annie

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Mrs Anna E. Sanders

(Address) 2666 Lehman Street

15- Filed Robert P. Harrison, Registrar.

JN2 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov 10, 1923, to June 20, 1924, that I last saw him alive on June 19, 1924, and that death occurred, on the date stated above, at 4.50 A.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jam M. D.

6-20-1924 (Address) Augusta & Frederick Aves

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	June 23, 1924
20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 N. Eutaw

EXACTLY. PHYSICIANS should be stated CAUSE OF DEATH. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 lks.

D 87996

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87996

CERTIFICATE OF DEATH.

100-08

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Charles Wilson

(a) Residence No.... Bay View Asylum St.,.... Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE.	If LESS than 1 day.
52 yrs. ..... mos. ..... ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Sailor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Sweden

PARENTS.

10-NAME OF FATHER, Charles Wilson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), ?

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country).

14- (Informant).... Bay View Hospital

(Address).....

15- Robert P. Harrison, Registrar.

JUN 21 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-20-24

17- I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 20, 1924, that I last saw him alive on June 20, 1924, and that death occurred, on the date stated above, at 12-15 noon m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

.....(Duration).....yrs.....mos. 2 ds.

CONTRIBUTORY (Secondary) Varicose ulcer - both legs -

un-fected.....(Duration) 1 yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. F. Fulton M. D.

, 19 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mount Cayvel Cem	June 21, 19..
20-UNDERTAKER.	**ADDRESS**
H. Lander Sons	1710 Read

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B R.S.—400 Bks.

D 87997

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Y. M. C. A. St., Cathedral & Franklin Sts. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Cassard

(a) Residence No. Y. M. C. A. St., 11 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? 67 yrs. 7 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Counne S. Cassard

6-DATE OF BIRTH (month, day and year) Nov-11-1856

7-AGE, 67 yrs. 7 mos. 8 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chemist

(b) General nature of industry, business, or establishment in which employed (or employer) Chemistry

(c) Name of employer Self

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER Lewis Cassard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland

12-MAIDEN NAME OF MOTHER Harriett Lippincott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Cincinnati Ohio

14- (Informant) S. S. Cassard - (son)

(Address) New York City

15- Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19-24

17- I HEREBY CERTIFY, That I attended deceased from June 9 19 24 to June 19 19 24

that I last saw him alive on June 19 19 24

and that death occurred, on the date stated above, at 1.05 P.M.

The CAUSE OF DEATH* was as follows:

Acute Cardio Dilatation

4 hours (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Tonsilitis

about 3½ weeks (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Y M C A

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. L. Keyser M.D.

, 19 (Address) 10 Gellworth Apt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Cemetery | DATE OF BURIAL, June 22nd 19 24

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) | ADDRESS 108 W. NORTH AVE.

JUN 21 1924

TO ... AND ... REAL ESTATE ... THAN

... TO APPEAR ON PERMANENT RECORDS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 87998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 87998

CERTIFICATE OF DEATH.

X 74001

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora Kelleher

(a) Residence No. Mount Hope Retreat St., 28 Ward Wilmington Del.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Kelleher

6-DATE OF BIRTH (month, day and year) Not Known

7-AGE.	If LESS than 1 day,
Abt 54 yrs. 0 mos. 0 ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (?) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Jeremiah Nolan

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town) (?) (State or Country), Ireland

14- (Informant) Records of Mt Hope Retreat

(Address) Mt Hope Baltimore

15- Robert P. Harrison,

Registrar.

Burial Permit Clerk.

N2 1 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 1st, 19 24, to June 20, 19 24, that I last saw her alive on June 20, 19 24, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(causing R. H. Paralysis)

Abt (Duration) 3 yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Def. Bychromia

Abt (Duration) 2 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Wilmington Del

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Frank J. Flannery M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Wilmington Delaware

DATE OF BURIAL, June 30, 19 24

20-UNDERTAKER STEWART & BROWER COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 87999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1924 D 87999

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Johnson. (C)

(a) RESIDENCE No 622 Greenwillow St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ---mos.---ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 24, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Enterprise Coal Co.

9 BIRTHPLACE (city or town) (State or country) Annapolis, Md.

PARENTS

10 NAME OF FATHER William Simms. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Johnson. (C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant William Simms. (C) father.
(Address) 1605 N. Mount St.

15 Filed NOV 21 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intra-cranial Hemorrhage, due to fracture of the skull, struck in head by axe

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Homicide

(duration) ....yrs. ....mos. ....ds.

(Signed) Otto R. Reinhardt M. D. (Coroner.)

June 19, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
622 Greenwillow St. June 14, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 6/21/1924

20 UNDERTAKER David Earhart

ADDRESS 916 Eutaw St.

Spec.—1-10-21—M&T—1500 Blks.

D 88000

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88000

CERTIFICATE OF DEATH.

X 116

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar De Kenney

(a) RESIDENCE NO. Bluff City, Tenn ST., WARD Bluff City Tenn.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Driver

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer 123

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10 NAME OF FATHER Sam De Kenney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Katharine Tenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

N2 T 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 20, 1924, that I last saw him alive on June 20, 1924, and that death occurred, on the date stated above, at 4:45 P. m.

The CAUSE OF DEATH* was as follows: obstructive Obstruction with disturbance

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 12-20

Was there an autopsy? No

What test confirmed diagnosis? Necessity

(Signed) J. P. Reichert M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bluff City Tenn

DATE OF BURIAL 6/21 1924

20 UNDERTAKER Joseph Abrams

ADDRESS 221 Bway

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88001

CERTIFICATE OF DEATH.

3 D 88001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 353 W. Preston ST., 11 WARD)

2-FULL NAME James E. Taylor

(a) RESIDENCE NO. 338 Preston ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of Industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER James Taylor

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Smith

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Annie Young
(Address) 2503 W. Fairmount

15 Filed JUN 21 1924, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1924

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1924, to June 18th, 1924, that I last saw h[illegible] alive on June 18th, 1924, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH was as follows:

Val. subtrendoid

(duration) yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. L. Ellis, M. D.

(Address) 824 Madison Ave

(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL 6/26 1924

20 UNDERTAKER R. L. Gross

ADDRESS 1405 McElderry

Burial Permit Clerk

N2 1 1924

MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 88002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 W. Hill St. ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hooks,

(a) RESIDENCE NO. 111 W. Hill St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	h Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Hooks.

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Josiah Hooks

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Kitty Moore

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Ella Cherry (Address) 111 W. Hill St.

15 Filed Robert P. Harrison, Registrar

N2 1 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 18, 1924, that I last saw him alive on June 18, 1924 and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

4 days. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

Not known. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical.

(Signed) Harry F. Brown, M. D.

6/20 1924 (Address) 1501 Presstman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 20, 1924
20 UNDERTAKER	ADDRESS
John H. Treadwell	1442 Linden Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88003

CERTIFICATE OF DEATH.

128 D 88003

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Smith ST.; 14 WARD)

2-FULL NAME Hattie Thomas

(a) RESIDENCE. No. 628 Smith ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Thomas

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
44 yrs.		6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Dilks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hagerstown, Md.

12 MAIDEN NAME OF MOTHER Matilda Hedgeman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Alexandria Va.

14 Informant Clara Robinson
(Address) 1728 N. Dallas

15 Filed JUN 21 1924 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1924

17

I HEREBY CERTIFY, That I attended deceased from April 15th, 1924, to June 19th, 1924.

that I last saw h e alive on June 19th, 1924.

and that death occurred, on the date stated above, at 6 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Exposure

(duration) yrs. mos. days ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Test.

(Signed) L. L. Chelton, M. D.

6/19/1924 (Address) 1320 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	June 21 1924
20 UNDERTAKER	ADDRESS
John H Toadvine	1472 Lexington St

JN 21 1924

THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88004

D 88004

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17 WARD)

2-FULL NAME John M Carthy

(a) RESIDENCE NO. 2017 Maryland Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 9 mos. 22 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen M Carthy

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	59	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John M Carthy

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Kelleher

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Hospital Record.
(Address)

15 Robert P. Harrison, Registrar

JN2 1 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/24

17

I HEREBY CERTIFY, That I attended deceased from 6/8/24, 19..., to 6/20/24, 19...,

that I last saw h-- alive on 6/20/24, 19

and that death occurred, on the date stated above, at 6.14 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. . mos. ... ds.

CONTRIBUTORY (Secondary) Carbuncle.

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted? 2
If not at place of death? Contracting Carbuncle

Did an operation precede death? Yes, Date of 6/9/24

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Lab.

(Signed) K. W. Hellen, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/23 1924
20 UNDERTAKER	**ADDRESS**
Henry W. Yeats & Son	805 N. Calvert

18.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 154 East St., 5 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Elizabeth Mayer

(a) Residence No.... 154 East St., Ward....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)....

(c) Name of employer....

9-BIRTHPLACE (city or town)... (State or Country), Md

PARENTS.

10-NAME OF FATHER, Henry Lawrence

11-BIRTHPLACE OF FATHER (city or town)... (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mariah Brack

13-BIRTHPLACE OF MOTHER (city or town)... (State or Country), Md

14- (Informant)... Ella A Wilson

(Address)... 154 East Ave

15- Filed... 192... Robert P. Harrison, Registrar.

Burial Permit Clerk.

JUN 21 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 19-24

17- I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to June 19, 1924,

that I last saw him alive on June 19, 1924,

and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

7 hours (Duration) yrs. mos. 7 hours

CONTRIBUTORY (Secondary) Arteria Sclerosis

Diabetes (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Edward Fisher M. D

6-20 1924 (Address) 1612 E Monument St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Academy Cemetery — DATE OF BURIAL, June 24 1924

20-UNDERTAKER, Mrs Ida Snowden — ADDRESS 1725 Ashland Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88006

CERTIFICATE OF DEATH.

129 D 88006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 Fulton Ave (St.) North (WARD) 20

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Smith

(Residence in Baltimore: No.) Home for Aged of the M. E. Church (St.) 65 yrs. ✓ mos. ✓ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, March (Month) 6 (Day), 1853 (Year)

7-AGE, 71 yrs. 3 mos. 14 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Smith.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cuddy

(Address) 400 N. Fulton Ave

15-

Filed....., 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

2 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 5 1923, to June 20 1924, that I saw h in life alive on June 20 1924, and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Hepatitis Chronic

(Duration) 3 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis —

(Duration) ✓ yrs. 4 mos. ✓ ds.

(Signed) George C. Shannon M. D.

June 21, 1924 (Address) 700 Fulton ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cem — DATE OF BURIAL, 6/23, 1924.

20-UNDERTAKER Geo. J. Smith — ADDRESS 1532 Pulton Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3400 O'Donnell St., 76 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ida L. Gross

(a) Residence No. 3400 O'Donnell St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~ Widow, Widowed, ~~or Divorced~~, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred Gross

6-DATE OF BIRTH (month, day and year) Feb. 6 1864

7-AGE 68 yrs. 4 mos. 13 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Fred. Bahlke

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

14-

(Informant) Albert Gross

(Address) 3400 O'Donnell St.

15-

Filed JUN 21 1924

Robert P. Harrison
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19 24

17- I HEREBY CERTIFY, That I attended deceased from May 20 1924 to June 19 1924

that I last saw h.r alive on June 18 1924

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Endarteritis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Robt J Green M. D.

6-19 1924 (Address) 120 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn	June 23 1924
20-UNDERTAKER	ADDRESS
Sirkler Bros	1734 Eager

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88008

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 McHenry ST. 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Birmingham

(a) RESIDENCE NO. 1808 McHenry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fmale	colrd	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1844

7 AGE 79 Years 11 Months 29 Days

If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Carrie M. Funk

(Address) 1808 McHenry St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

JN 21 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to June 20, 1924, that I last saw h alive on June 19, 1924, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Thos Waldenmeyer M.D.

June 21/24 (Address) 1900 n Ballimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem | DATE OF BURIAL: June 23 1924

20 UNDERTAKER: Krull & Son | ADDRESS: 1729 W Pratt

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may b TION is very important. See instructions on back o

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 88009 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Calhoun St., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Bennett

(a) RESIDENCE NO. 910 N. Calhoun St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly M. Bennett

6 DATE OF BIRTH (month, day, and year) Oct. 29 1882

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ansonia Porcelain
(c) Name of employer Curtis Bay.

9 BIRTHPLACE (city or town) (State or country) Md, U.S.

PARENTS

10 NAME OF FATHER George Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lilly Bennett
(Address) 910 N. Calhoun St.

15 Filed JUN 21 1924, 192 ..... Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

..... (duration) 1 yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) ms Enteritis

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hemberger, M. D.
(Coroner.)

June 20, 1924 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemtery	June 22 1924
20 UNDERTAKER Mrs James H. Dennis per T E Kelam	ADDRESS 1303 Presstmans St

N2 1 1924

Spec.—1-10-21—MAT—1500 Blks.

D 88010

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88010

CERTIFICATE OF DEATH.

REGISTERED NO. 15 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Genl Hosp. ST., WARD)

2-FULL NAME Mr. Kenneth L. Simms

(a) RESIDENCE NO. 3300 Garrison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? 45 yrs. 11 mos. 2 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Furniture

(c) Name of employer F. J. Schellenberg

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm C. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Anne V. Simms

(Address) 3300 Garrison Ave

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-13, 1924, to 6-20, 1924,

that I last saw him alive on 6-20, 1924,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia; Cardiac failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) John A. Lamplough, M. D.

19 (Address) Md. Genl Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL June 23 1924

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

JN 21 1924

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Blks.

17 2P 74 88011

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 145-B 88011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hollen

(a) RESIDENCE NO. Buchanan W. Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ——— yrs. ——— mos. 12 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Orra Hollen

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Wellington Tallman

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Catherine Right

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

JN 21 1924 , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1924, to June 21, 1924, that I last saw h[illegible] alive on June 21, 1924, and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

Des. ..... (duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Appendicitis acute perforated ruptured gallbl.

(duration) ... yrs. 5 mos. ... ds.

18 Where was disease contracted if not at place of death? at Buchanan W Va.

Did an operation precede death? Yes. Date of 6-7-24.

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) R W Le Linde, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buchanan W Va	Jun 21 1924
20 UNDERTAKER	ADDRESS
Joseph Givens	221 Bway

WARNING.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 88012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88012

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 Alameda Blvd. WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Brown

(a) RESIDENCE NO. 1837 Alameda Blvd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter J. Brown

6 DATE OF BIRTH (month, day, and year) Sept. 7th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown Md.

PARENTS

10 NAME OF FATHER Chas. H. Kenton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Andrew Eck

(Address) 1837 Alameda Blvd

15 Filed JUN 21 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1924

17 I HEREBY CERTIFY, That I attended deceased from September 12 1923 to June 18 1924.

that I last saw her alive on June 18 1924,

and that death occurred, on the date stated above, at 1.45 p m.

The CAUSE OF DEATH* was as follows:

Adeno Carcinoma of the Ovaries and Valvular disease of Heart (duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. One mos. ds.

18 Where was disease contracted if not at place of death? in Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Huntsook M. D.

(Address) 1616 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 6/21/1924

20 UNDERTAKER E. J. Fanning & Son — 1938 E. Lafayette Ave. — ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 88013

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88013

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Lewis St ST., 5 WARD)

2-FULL NAME Nathaniel Torny

(a) RESIDENCE NO 404 Lewis St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXX

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rag-picker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant N.E.Police Dept.
(Address) Robert P. Harrison,

15 Filed JUN 21 1924, 192 ..... Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Probably 6/12/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency
(History - Probably Bronchopneumonia 3 wks ago)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. H. Pale, M. D.
(Coroner.)

6/19/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	JUN 24 1924 192
20 UNDERTAKER	ADDRESS

Health Officer

JUN 24 1924

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Duplicate

D 88014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88014

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

2-FULL NAME Edward Short

(a) RESIDENCE NO. 1412 Druid Hill Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Short

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 54

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cantonsville Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Records Johns Hopkins Hospital

15 Filed JUN 21 1924, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1924

17

I HEREBY CERTIFY, That I attended deceased from June 8th, 1924, to June 18th, 1924.

that I last saw him alive on June 18th, 1924,

and that death occurred, on the date stated above, at 915 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Myocarditis

Asphyxia Chronic Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) T. R. Harmon M. D.

6/17, 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cantonsville Md	June 20 24
20 UNDERTAKER	ADDRESS
Emmert & Kennedy	Md Ave

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88015

CERTIFICATE OF DEATH.

175 D 88015

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1012 N. Gilmor St., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Olivia Smith

(a) RESIDENCE. NO. 1012 N. Gilmor ST., 15th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Lifes How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm [redacted] Eddie

11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant William J. Smith
(Address) 1012 N. Gilmor

15 Filed JUN 21 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19th 1924, to June 20th 1924, that I last saw h.. alive on June 20th 1924, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Ptomaine Poisoning

(duration) yrs. 12 hours mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Jas. Eddie Bell M. D.

6-20 1924 (Address) 1024 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 24 1924
20 UNDERTAKER	ADDRESS
Sam'l W. Chasetten	140 Mosher

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Cor.—1-12-21—M&T—100 Bks.

D 88016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert C. Bethea

(a) RESIDENCE NO. Latta S.C. ST., WARD Latta S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Robert Bethea

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER: Grace Utley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C.

14 Informant: Johns Hopkins Hospital
(Address)

15 Filed JUN 21 1924, 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Spine-lower cervical region-Accidental- Struck sand bar while diving, (swimming for pleasure on June 13/24)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Pyonephrosis)
(duration) yrs. mos. ds.

(Signed) J. S. H. Pollitt, M. D.
(Coroner.)

6/21/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Latta S. C.	6-21 1924
20 UNDERTAKER	ADDRESS
Joseph Ahern	231 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Funt

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 89 D 88017

D 88017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Ida Funt

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) Fairmont, W. Va.

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? 16 yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Isaac Funt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Roll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Funtown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Baltimore St

15 Filed JUN 21 1924, 19.....

ROBERT R. KRAUTER,
Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 20, 1924, that I last saw h[illegible] alive on June 20, 1924, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 6 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor D. Fry M. D.

June 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York — DATE OF BURIAL June 21 1924

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—3500 Hbs.

172145 D 88018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D 88018

JOHNS HOPKINS HOSPITAL

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... St., 7 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delia Jarvis

(a) RESIDENCE NO. Parkersburg W Va St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William Jarvis

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Ohio

PARENTS

10 NAME OF FATHER John Scott

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ohio

12 MAIDEN NAME OF MOTHER Sarah Cook

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ohio

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 22 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 21, 1924, that I last saw her alive on June 21, 1924, and that death occurred, on the date stated above, at 3 40 a.m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

Myocardial insufficiency

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Arn Jacobson, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkersburg W. Va. DATE OF BURIAL June 27 1924

20 UNDERTAKER William G. Schaefer ADDRESS 1816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 88019

CERTIFICATE OF DEATH.

88019

1-PLACE OF DEATH University Hosp 14 x 90

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alverta Spriggle

(a) RESIDENCE NO. Lime Boro Md ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T Spriggle

6 DATE OF BIRTH (month, day, and year) July 3 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo Dayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elgine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John F Spriggle
(Address) Glenn Rock Md.

15 Filed JUN 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1924, to June 21, 1924, that I last saw her alive on June 21, 1924, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Auricular fibrillation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lime Boro Md. — DATE OF BURIAL June 23 1924

20 UNDERTAKER W M Routson — ADDRESS 2208 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS ... MENT RECORD. Every item ... should be carefully supplied. AGE should be ... EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be prop... classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

88020 ✓ 90 D 88020

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs David Livingston

(a) RESIDENCE NO. Tulsa, Oklahoma ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct, 1 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in Oil.

(b) General nature of industry, business, or establishment in which employed (or employer) 445

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Nathan C. Livingston

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Anna Goldston

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Hospital (Address)

15 JUN 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1924, to June 20, 1924, that I last saw him alive on June 20, 1924, and that death occurred, on the date stated above, at 5.55 a m.

The CAUSE OF DEATH* was as follows:

Streptococcus viridans Endocarditis with Constant discharge of Emboli

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Discharge of Emboli & Pulmonary infarct

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Tulsa. Oklahoma.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture.

(Signed) Raymond F Johnston, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bals Hebrew Cem	6-22 19 24
20 UNDERTAKER	ADDRESS
Jack Lewis	1436 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88021

CERTIFICATE OF DEATH.

118-002 88021

D 88021

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Lyons

(a) RESIDENCE NO. 1023 N Broadway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 869

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosa Rosen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 Eutaw St

15 JUN 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 | 21 | 1924

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to June 21, 1924.

that I last saw h[illegible] alive on June 21, 1924

and that death occurred, on the date stated above, at 12:40 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/20/24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isidore L. Levy, M. D.

June 19 24 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington — DATE OF BURIAL: 6/22 1924

20 UNDERTAKER: Jack Lewis 1439 Eutaw St — ADDRESS

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88022

D 88022

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

49 D 88022

Registered No.....

City of BALTIMORE: (No. 241 S. Eden St. 3 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME A. Benjamin Miller

(a) Residence No. 241 S. Eden St St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M

4-COLOR OR RACE, W

5-Single, Married, Widowed, M or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 74 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Jack Lewis

(Address) 1429 E Baltimore St

15- Filed JUN 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/21/24

17- I HEREBY CERTIFY, That I attended deceased from June 16 1924 to June 21 1924

that I last saw him alive on June 20, 1924

and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH was as follows:

Oesophageal obstruction

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Abraham Schapiro M. D

, 19 (Address) 2029 W North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Rehoboth Mash Rd | DATE OF BURIAL, 6/22, 1924

20-UNDERTAKER. Jack Lewis | ADDRESS 1429 E Balt

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88023

CERTIFICATE OF DEATH.

D 88023 11-00 D 88023

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1368 Woodyear ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Cotton

(Residence in Baltimore: No. 1368 Woodyear St.; 74 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 24, 1849 (Month) (Day) (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work 040
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country) Balto County Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cotton

(Address) 1368 Woodyear St.

15-

Filed JUN 7 1924, 191.... ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 5/19 1924, to 6/19 1924, that I saw h alive on Jun 6/19 1924, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) Burk Roberts M. D.

6/20, 1924 (Address) 2139 D. H. Sq

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, June 22 1924

20-UNDERTAKER Jesse Redden

ADDRESS 432 Bridge St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88024.

D 88024

CERTIFICATE OF DEATH.

33 D 88024

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1322 N. Calhoun ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estelle Moulden.

(a) RESIDENCE NO. 1322 N. Calhoun. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 18-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work waitress 170

(b) General nature of industry, business, or establishment in which employed (or employer) ice-cream.

(c) Name of employer Dobremier

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Octavius Moulden.

11 BIRTHPLACE OF FATHER (city or town) Calvert Co, (State or country) Md.

12 MAIDEN NAME OF MOTHER Amelia Curtis

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co, (State or country) Md.

14 Informant Mary Henson. (Address) 1322 N. Calhoun St.

15 FILED JUN 2 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20. 1924

17

I HEREBY CERTIFY, That I attended deceased from June 14 1924, to June 20 1924, that I last saw her alive on 18th 1924, and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Riland., M. D.

6-21 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL June 23 1924

20 UNDERTAKER Jos E Redden ADDRESS 436 Gilmor

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

0088026

D 88025

CERTIFICATE OF DEATH.

100 D 88025

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., 15 Ward)

2-FULL NAME Moses Sneil

(a) RESIDENCE No. 3617 Pristerstown Road St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. 6 mos. 6 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President Harvey 186

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Michael Sneil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Dora Eisner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Louis Sneil

(Address) 2203 Bryan ave

15 JUN2 21924 ROBERT R. KRAUTER, Burial Permit Clerk. Return.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1924 to June 21, 1924.

that I last saw him alive on June 21, 1924

and that death occurred, on the date stated above, at 3.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & Lab.

(Signed) Isidor J. Levy M. D.

June 1924 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 6/24/1924

20 UNDERTAKER Sol Levinson Bro — ADDRESS 1127 E Balto St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88026

CERTIFICATE OF DEATH.

129 D 88026

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Johnson ST., 24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brigida Di Leonardi

(a) RESIDENCE NO. 1712 Johnson ST., 24 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Marsala Italy

PARENTS

10 NAME OF FATHER Pietro Pipitone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rose Alagna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vito Di Leonardi
(Address) 1809 Light st

JUN 2 1924

ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1924

17 I HEREBY CERTIFY, That I attended deceased from 5-18- 1924 to 6-19 1924.

that I last saw h[illegible] alive on 6-18 1924

and that death occurred, on the date stated above, at 10 P t m.

The CAUSE OF DEATH* was as follows:

General Cellero sclerosis.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. DeMarco M. D.

6-23-24 (Address) 1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 23rd June 1924

20 UNDERTAKER Frank V. Pipitone

ADDRESS 1800 E. 32nd St

Spec.—12-23-21—E.B.R.S.—400 Blks.

Leikam

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88027

CERTIFICATE OF DEATH.

45 88027

D 88027 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1736 S. Potomac St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Joseph Leikam.

(a) Residence No. 1736 S. Potomac St St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of May Leikam.

6-DATE OF BIRTH (month, day and year) March 19-1857

7-AGE.	If LESS than 1 day,
67 yrs. 3 mos. ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Hostler 1924

(b) General nature of Industry, business, or establishment in which employed (or employer)..... P. M. Wombir

(c) Name of employer..... Lumber Co.

9-BIRTHPLACE (city or town)..... (State or Country). Germany.

PARENTS.

10-NAME OF FATHER. Joseph Leikam.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany.

14- (Informant)..... Mary Leikam.

(Address)..... 1736 S. Potomac St.

15- Filed JUN 21 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19-1924

17- I HEREBY CERTIFY, That I attended deceased from May 15 1924 to June 19 1924

that I last saw him alive on June 19 1924

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon & Bladder

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tatlow M. D

6/20 1924 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Sand Hill Cem	June 23 1924

20-UNDERTAKER. H. Zeller ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARBLE RESERVED FOR BINDING.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88028

Registered No. 172 D 88028

1-PLACE OF DEATH

City of BALTIMORE: (No. 3038 Elliott St. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Linz

(a) Residence No. 3038 Elliott St St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Linz.

6-DATE OF BIRTH (month, day and year) Dec. 3-1850

7-AGE. 73 yrs. 6 mos. 17 ds. If LESS than 1 day, hrs. or mlo.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany.

PARENTS

10-NAME OF FATHER, Sebastian Stark

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Maria Junker.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) John Linz.

(Address) 3038 Elliott St.

15. JUN 2 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19-1924

17- I HEREBY CERTIFY, That I attended deceased from Jan 25 1921 to June 19 1924

that I last saw h. alive on June 19 1924

and that death occurred, on the date stated above, at 11.59P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M J McAvoy M. D

June 20 1924 (Address) 839 N. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Bayview Mausoleum	June 23. 1924
20-UNDERTAKER.	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88029

CERTIFICATE OF DEATH.

90 88029

D 88029
Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 575 Oxford St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Maria Johnson

(a) Residence No..... 575 Oxford St., ... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 60 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... 870

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Baltimore City
(State or Country).....

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town)..... Unknown
(State or Country).....

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Unknown
(State or Country).....

14- (Informant)..... Richard Hammon

(Address)..... 575 Oxford St.

15- Filed ..... 192 ROBERT R. KRAUTER, Registrar.

JUN 21 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/20/1924

17- I HEREBY CERTIFY, That I attended deceased from May 6, 1924, to June 20, 1924, that I last saw h.. alive on June 15, 1924, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Interstitial myocarditis

(Duration) 1 or 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. F. Chamwell, M. D.

June 21, 1924 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 6/23, 1924
Mt Auburn Cem	
20-UNDERTAKER. Rand Tarbert	ADDRESS 716 Park Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

88030

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88030

CERTIFICATE OF DEATH.

D 88030

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 N Stockton St. 18 100-90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes K Williams

(a) Residence No. 109 N Stockton St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 16 1923

7-AGE: ....yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: James Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Woods

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-

(Informant): Mary Williams

(Address): 109 N. Stockton St

15-FILED JUN 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6/20/24

17- I HEREBY CERTIFY, That I attended deceased from June 15, 19 24 to June 20, 19 24 that I last saw h.. alive on June 20, 19 24, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio-Pneumonia.

(Primary.)

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY —

(Secondary)

(Duration) — yrs. — mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

6/20/24 (Signed) J. Thos Norton, M. D.

(Address) 888 N. Loudon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Bal

DATE OF BURIAL: 6/23/24

20-UNDERTAKER: Samuel Easton

ADDRESS 916 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D 88031 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 88031

CERTIFICATE OF DEATH. 31 D 88031

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St. Municpal Tuberculosis Hospital 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella B. Holly

(a) Residence No. 701 N. Carey st. St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Separated

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) 1899

7-AGE.	If LESS than 1 day.
25 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook 21

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER. Levy Baker

11-BIRTHPLACE OF FATHER (city or town) (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Cecelia Valentine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). North Carolina

14- (Informant) Hospital Records

(Address) M.T.H.

15- FILED JUN 21 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 19, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 22 1924, to June 19 1924,

that I last saw h. 6r alive on June 19 1924,

and that death occurred, on the date stated above, at 8.30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum

(Signed) L. A. Lally M. D

6-19 1924 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	6/23/24
20-UNDERTAKER.	ADDRESS
Dent Taylor	Cadiz

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 88032

D 88032

CERTIFICATE OF DEATH.

Registered No. D 88032

1-PLACE OF DEATH

City of BALTIMORE: (No. 705 Brunn St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Brown

(a) Residence No. 705 Brunn St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Va

PARENTS.

10-NAME OF FATHER, But Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Bed Taylor

12-MAIDEN NAME OF MOTHER Bullock

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Bed Taylor

14-

(Informant) Mary Lewis

(Address) 1106 Brunn St

15-

Filed JUN 2 1924 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20-24

17- I HEREBY CERTIFY, That I attended deceased from June 5 — 19 24 to June 20 19 24

that I last saw her alive on June 20 19 24

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Asthma Dropsy +

Nephritis (Duration) yrs. 2 mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dwight Bernard M. D.

6-21 19 24 (Address) 708 Ensor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	6/23/24
20-UNDERTAKER.	ADDRESS.
Dunn Easton	Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88033

REGISTERED NO. 74-001 88033 D 88033

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1532 McCulloh ST., 14 WARD)

2-FULL NAME Mary Hare

(a) RESIDENCE NO. 1532 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hare

6 DATE OF BIRTH (month, day, and year) — — 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co Md

PARENTS

10 NAME OF FATHER Geo. H. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frdk Co Md

12 MAIDEN NAME OF MOTHER Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frdk Co Md

14 Informant Leonard Coombs

(Address) 1532 McCulloh St

JUN 2 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19. 1924

17

I HEREBY CERTIFY, That I attended deceased from June 19, 19 24 to June 19 19 24.

that I last saw h.r. alive on June 19 19 24.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Coma)

(duration) yrs. 12 hrs. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

6/20. 1924 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6/23 1924

20 UNDERTAKER Daniel Easter

ADDRESS 916

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88034

D 88034

CERTIFICATE OF DEATH.

REGISTERED NO. [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5228 Palmer St., Ave. Allegheny 27 WARD) 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J Gerber

(a) RESIDENCE NO. 5228 Palmer ST. One WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 0 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) July 20, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	11	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles F Gerber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen J Buske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mother (Mrs Gerber)

(Address) 5228 Palmer Ave

15 Filed JUN 22 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 20, 1924, that I last saw h[illegible] alive on June 20, 1924, and that death occurred, on the date stated above, at 12 — m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Excessive heat.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Chas. B. Evans, M. D.

6-21. 1924 (Address) 5016 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 23rd 24
20 UNDERTAKER	ADDRESS
H. Vanden & Sons	710 Fleet St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88035

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 617 Glenwood Ave St., 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elsa Sandra Wareheim

(a) Residence No. 617 Glenwood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) January 19, 1923

7-AGE, 1 yrs. 5 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Balto Md.....
(State or Country),

PARENTS.

10-NAME OF FATHER Reason F Wareheim

11-BIRTHPLACE OF FATHER (city or town) Carroll Co.....
(State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah E. Warfield

13-BIRTHPLACE OF MOTHER (city or town) Balto
(State or Country),

14- (Informant) Reason F. Wareheim

(Address) 617 Glenwood Ave

15- Filed JUN 2 1924 19.. ROBERT R. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21-1924

17- I HEREBY CERTIFY, That I attended deceased from June 17, 19 24 to June 21, 19 24, that I last saw h/e alive on June 20, 19 24, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Chiles Media

.....(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Premature Birth

.....(Duration).....yrs.....mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) H W Wheaton, M. D.

, 19 (Address) 7-39 York Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19 24
Loudon Park	6/23
20-UNDERTAKER M Cook	ADDRESS 1022 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88036 ✓ D 88036

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 758 Bartlett Ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George T. Hamilton

(a) Residence No. 758 Bartlett Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Rosa M Hamilton

6-DATE OF BIRTH (month, day and year) Sept 17 1880

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Adjuster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Md Casualty Co

9-BIRTHPLACE (city or town) (State or Country), Talbot Co

PARENTS.

10-NAME OF FATHER Thomas Hamilton

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Talbot Co

12-MAIDEN NAME OF MOTHER Martha Neal

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Talbot Co

14- (Informant) Rosa M Hamilton

(Address) 758 Bartlett Ave

15- JUN 2 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 4/24

17- I HEREBY CERTIFY, That I attended deceased from June 5th, 1924, to June 4th, 1924, that I last saw him alive on June 18, 1924, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

a Chronic Endocarditis

Not Known (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Sidney D. Gruse M. D.

, 19 (Address) 727 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Wood Lawn Cem	6/23 1924
20-UNDERTAKER.	ADDRESS
Williamson & Nalle	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88037
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 88037
Registered No.

City of BALTIMORE: (No. 1900 Ramsay St. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dreher

(a) Residence No. 1900 Ramsay St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown

7-AGE, About 69 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Western Md R.R.
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Germany

14-
(Informant) Elizabeth Bingel
(Address) 1900 Ramsay St

15-
Filed JUN 21 1924 19 ROBERT R. KRAUTH Registrar.

Burial Permit Cheri

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 19/24

17- I HEREBY CERTIFY, That I attended deceased from April 16, 1924, to June 19, 1924, that I last saw him alive on June 18, 1924, and that death occurred, on the date stated above, at 1005 P

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Raymond Hamer M. D.

June 20 1924 (Address) Fallstaff

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Lorraine | DATE OF BURIAL, 6-23, 1924

20-UNDERTAKER, William Cook | ADDRESS 502 E North

Spec—12-23-21—E.B.R.S.—400 Bks.

8 Silverstein 22 S Broadway Dolly 3880 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88038

CERTIFICATE OF DEATH.

129 D 88038

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 915 South Caroline St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry L Miller

(a) Residence No. 915 South Caroline St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	W	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Miller

6-DATE OF BIRTH (month, day and year) Aug 29, 1868

7-AGE. 55 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer)..... Building 062

(c) Name of employer..... City Hall

9-BIRTHPLACE (city or town)..... Bath
(State or Country), Md

PARENTS.

10-NAME OF FATHER Levy Miller

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Penna

12-MAIDEN NAME OF MOTHER Rebecca Rennoker

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Penna.

14- (Informant)..... Lotty Brandy
(Address)..... 915 So Caroline St

15- Filed JUN 21 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit C.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 16 1924 to June 18 1924

that I last saw h. living on June 18 1924

and that death occurred, on the date stated above, at 10:20 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Examination

(Signed) Samuel Silverstein M. D

, 19 (Address) 22 S. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Olivet	June 23 1924

20-UNDERTAKER.	ADDRESS
Wm Cook	503 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88039

CERTIFICATE OF DEATH.

101-001 ✓

D 88039

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 522 St Mary's ST., 17 (WARD)

2-FULL NAME Charles Simmons

(a) RESIDENCE NO. 522 St Mary's ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE — Years: 44 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Chase City Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Martha Hawkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Minnie Gordon
(Address) 522 St Mary's St

15 JUN 2 2 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Jun 18, 1924. to Jun 21, 1924

that I last saw h[illegible] alive on Jun 21, 1924

and that death occurred, on the date stated above, at a' m.

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T H Yeuch, M. D.

(Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Portsmouth Va — DATE OF BURIAL: 6/22/24

20 UNDERTAKER: Samuel D Wesley — ADDRESS: [illegible] Bolton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Blks.

D 88040

D 88040 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00 D [redacted]

1-PLACE OF DEATH

City of BALTIMORE: (No. 1406 E Chase St. 10 Ward) Registered No.....

2-FULL NAME... Mathias Hammel

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1406 E Chase St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Hammel

6-DATE OF BIRTH (month, day and year) Feb 5 1843

7-AGE. 81 yrs. 4 mos. 15 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 40

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Geo Hammel

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Not known

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Germany

14-Informant. Geo. Hammel

(Address) 1406 E Chase St

15-Filed JUN 2 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20, 1924

17-I HEREBY CERTIFY, That I attended deceased from May 18, 1924 to June 20, 1924

that I last saw him alive on 1924

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Uremia – Sclerosis

Did not Know (Duration) yrs. mos. ds.

CONTRIBUTORY Senile Gangrene of Toes (Secondary)

Arteriosclerosis (Duration) yrs. 1 mos. 1/2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

June 21, 1924 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Emanuel

DATE OF BURIAL. June 23, 1924

20-UNDERTAKER. L. Neeman.

ADDRESS 30 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 88041

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1813 N. Bond st St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Harris

(a) Residence No. 1893 N Bond st St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov 2 1844

7-AGE. 80 yrs. 7 mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), England.

PARENTS.

10-NAME OF FATHER, Charles Big Wather

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England.

12-MAIDEN NAME OF MOTHER, E. Big Wather

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England.

14- (Informant) John Harris

(Address) 1813 N. Bond st.

15- JUN 2 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20-/24

17- I HEREBY CERTIFY, That I attended deceased from April 8- 1924 to June 20- 1924

that I last saw h.. alive on June 19- 1924

and that death occurred, on the date stated above, at 4.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

unknown (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms.

(Signed) C Carlos Geist M. D

June 24. 1924 (Address) 1111 W. Lanvale St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St John Cemetery Waverly.	June 23 1924
20-UNDERTAKER.	ADDRESS
Geo. J. Roth	1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-21—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88042

CERTIFICATE OF DEATH.

D 88042

1924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna Johnson

(a) RESIDENCE No. 417 D Hillman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	col	Married

5a If married, widowed, or divorced
If ~~HUSBAND of~~ (or) WIFE of Howard Johnson

6 DATE OF BIRTH (month, day, and year) Oct. 4-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER George Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sally Garrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sally Robinson (Address) 417 D Hillman Ave.

15 JUN 2 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 Jun 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or ~~inquiry~~) thereon and from the evidence obtained by said ..... Inquest, autopsy or ~~inquiry~~) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

I Harmonage Bowel Fever 3 days

(duration) yrs. 24 mos. ds.

CONTRIBUTORY (Secondary) Acute Suppurative Cystitis

(duration) yrs. mos. ds.

(Signed) W. R. Gonce, M. D.
(Coroner.)

6/20, 1924 (Address) 117 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 23rd 1924
20 UNDERTAKER Jno. M. Johnson	ADDRESS 130 D Hillman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88043

CERTIFICATE OF DEATH.

D 88043

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital 15 St. ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Burke

(a) Residence No. 1910 Braddish ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Separated

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6-DATE OF BIRTH (month, day and year): May 20 1899

7-AGE: 25 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Operator

(b) General nature of industry, business, or establishment in which employed (or employer): Sewing factory

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: John Ross

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Ada Martin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Hospital Records

(Address): M.T.H.

15- Filed JUN 23 1924 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from Feb. 21 1924 to June 20 1924

that I last saw her alive on June 20 1924

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray, Sputum

(Signed) L. A. Lalk M. D

6-20-, 1924 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Bath Cemetery DATE OF BURIAL: June 23 1924

20-UNDERTAKER: F. D. Hupfeld ADDRESS 2236 Fleet Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88044

D 88044

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2820 Frederick Av ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt J. Hammond

(a) RESIDENCE No. 2820 Frederick Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 8 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	12	8	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Cecil Co. Md

PARENTS

10 NAME OF FATHER Robt. J. Hammond

11 BIRTHPLACE OF FATHER (City or town) (State or country) Cecil Co. Md

12 MAIDEN NAME OF MOTHER Mary Steelman

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Cecil Co. Md

14 Informant Mary 2820 Frederick Av
(Address)

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & Internal injuries

(duration) ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fell off Race Dep at Pleasure Road Park

(Signed) Jas. B. Horton M. D.

June 21 1924 (Address) Curtis Bay, Md.

*(State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 23 1924
20 UNDERTAKER	ADDRESS
H B Kespert	2236 Frederick Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-002

D 88045

REGISTERED NO.

1-PLACE OF DEATH Franklin

CITY OF BALTIMORE: (No. 1218 Saint Paul St. WARD 18)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helmig H. Rohrbach

(a) RESIDENCE No. 1218 St. Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. S. Rinier

6 DATE OF BIRTH (month, day, and year) Aug 22 1897

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
26	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Rohrbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Addie Hemmeter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Jacob Rohrbach 1218 St. Balto

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1924, to June 21, 1924.

That I last saw h[illegible] alive on June 20, 1924

And that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

1 Tuberculosis Pneumonia

3 (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Anemia and Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 17 24

Was there an autopsy? No

What test confirmed diagnosis? Lab. Ct.

(Signed) F. B. Blackburn, M. D.

19 (Address) 320 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 24 1924
20 UNDERTAKER	ADDRESS
F. B. Blackburn	1850 N. Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88046

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 Wyman Ave. Ward 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William J. Starr

(a) Residence No.. 314 Wyman Ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1884.

7-AGE.	If LESS than 1 day.
40 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)..... Rothrock & Goldsburgh

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), W. Va. Washington Co.

PARENTS.

10-NAME OF FATHER, James Starr

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Gallagher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant)..... Mary Welch

(Address) 314 Wyman Ave.

15- Filed..... 192.. ROBERT R. KRAUTER, Registrar.

JUN 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 19 1924

17- I HEREBY CERTIFY, That I attended deceased from May 20, 19 24 to June 19, 19 24

that I last saw him alive on June 19, 19 24

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 6 - 24

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goldsborough, M. D.

, 19 (Address) 2923 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Mays Cemetery Sparrows	June 23, 1924
20-UNDERTAKER,	ADDRESS
Martin Fahey	1827 W North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 88047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D 88047

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mount Hope Retreat ST. 28th WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Zeller

(Residence in Baltimore: No. Mount Hope Retreat St.: 47 yrs., 8 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, Sept (Month) 19 (Day), 1880 (Year)

7-AGE, 44 yrs. 9 mos. 1 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer): X

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jos. A. Zeller

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary J O'Neill

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records of Mt Hope Retreat

(Address) Mt Hope Baltimore Md.

15- —

Filed JUN 21 1924, 191.... ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Manic Psychosis

(Duration) 18 yrs. 0 mos. 0 ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

June 20, 1924 (Address) 2803 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 18 yrs. 0 mos. ....ds. In the State Life yrs. ....mos. ....ds

Where was disease contracted, if not at place of death? Mt Hope Retreat

Former or usual residence Baltimore Md.

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Cathedral	June 22, 1924

20-UNDERTAKER Martin Kehoe ADDRESS 527 N North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88048

CERTIFICATE OF DEATH.

129

D 88048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Ridgely Ave. near Rush St.) ST. 27 (WARD)

2-FULL NAME Charles L. Peregoy

(a) RESIDENCE NO. Ridgely Ave near Rush St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of Florence Peregoy

6 DATE OF BIRTH (month, day, and year) Nov. 21-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	30	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Peregoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Agnes M. Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Florence Peregoy

(Address) Ridgely Ave near Rush St.

15 Filed JUN 23 1924 ROBERT P. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to June 20, 1924, that I last saw h[illegible] alive on June 20, 1924 and that death occurred, on the date stated above, at 8 12 P m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer.

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray & Autopsy

(Signed) H. A. Dooley, M. D.

, 19 (Address) 2101 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 23 19 24
20 UNDERTAKER Howard F. Bulger	ADDRESS 503 Fallsway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88049 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 88049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1467 Woodall ST., 24 WARD)

2-FULL NAME Clara L. Meyers

(a) RESIDENCE No. 1467 Woodall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Meyers

6 DATE OF BIRTH (month, day, and year) March 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Fraley

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Brant

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant (Address) Wm. H. Meyers 1467 Woodall St.

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to June 20, 1924

that I last saw h she alive on June 20, 1924

and that death occurred, on the date stated above, at 11-45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

About (Duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

June 21, 1924 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Holy Cross Cem. Q.A.	June 23 1924
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88050
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered D 88050

City of BALTIMORE: (No. 534 S Bond St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Kurka

(Residence in Baltimore: No. 534 S Bond St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Aug (Month) 13 (Day) 1893 (Year)

7-AGE. 28 yrs. 10 mos. 7 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of Industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Sebastian Kurka

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Margaret Gras

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margabet Kurka

(Address) 534 S Bond St

15-
FILED JUN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day) 192...4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M Hunter M. D. (Coroner.)

June 24 192 4 (Address) 707 E Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 23 1924

20-UNDERTAKER.	ADDRESS
John Malloy	1803 Bank St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88051

CERTIFICATE OF DEATH.

11

D 88051

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH South Oddo Gen Hosp

CITY OF BALTIMORE: (No. 1213 Light St. ST., 16 WARD)

2-FULL NAME Mrs Mary E Kroeger

(a) RESIDENCE No. 1027 N Fulton Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 26 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Caspar Kauffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Barbara McMurray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Mrs. Robert Austin

(Address) 1027 N Fulton Ave

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21 1924

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1924, to 6/21, 1924.

that I last saw her alive on 6/21, 1924

and that death occurred, on the date stated above at 3:15 P m.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 6/20/24

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) F A Hoffmann, M. D.

, 19 (Address) 1629 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 24 1924
20 UNDERTAKER Henry W. Maus & Son	ADDRESS 805 N. CALVERT

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 88052
Registered No.

1-PLACE OF DEATH
City of BALTIMORE, (No. 209 S. East ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Edward McAvoy

(a) Residence No. 209 S. East ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Roseanna

6-DATE OF BIRTH (month, day and year) May 18-1851

7-AGE. 23 yrs. 1 mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Drayman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Michael McAvoy

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ann Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14-(Informant) Jno McAvoy
(Address) 209 S. East ave

15-Filed JUN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1 1924 to June 20 1924 that I last saw him alive on June 19 1924 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

6/21, 1924 (Signed) Horace B. Sithens M. D (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem. DATE OF BURIAL. June 23 1924

20-UNDERTAKER. J. J. Moran ADDRESS 3000 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88053

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

162

D 88053

Registered No.....

City of BALTIMORE: (No. 101 N Lakewood Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Richard Leon Fullender Jr.

(a) Residence No. 101 N Lakewood Ave St., Ward.....

(Usual place of abode) (If non-resident give city and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 21-24

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, 11 hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... ppd

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, W L Fullender

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Alice Zelenosky

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

14- (Informant) W L Fullender

(Address) 101 N Lakewood Ave

15- Filed JUN 23 1924 ROBERT R. KEMLER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 22/24

17- I HEREBY CERTIFY, That I attended deceased from June 21 19.24 to June 22 19.24

that I last saw h.e alive on June 22 19.24

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Total Anuria

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William J. Tyson & Co. M.D.

June 23 1924 (Address) 804 N Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	June 23..., 1924
20-UNDERTAKER.	**ADDRESS**
August Basek	721 North Glover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88054

CERTIFICATE OF DEATH.

129 D 88054

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 303 Dolphin St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Phoebe D. Clarke

(a) Residence No. 303 Dolphin St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Aug 8. 1875

7-AGE. 48 yrs. 10 mos. 13 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS

10-NAME OF FATHER. Henry E. Clarke

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Francis Langton

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Eliz. J. Clarke

(Address) 303 Dolphin St

15- ROBERT R. KRAUTER,

Filed ..... 192.. Registrar.

JUN 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21/24

17- I HEREBY CERTIFY, That I attended deceased from Apr 28 19 24 to June 21 19 24

that I last saw h. alive on June 21 19 24

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

3

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Microscopic exam.

(Signed) Emmett M. Baker M. D.

6/25, 1924 (Address) 3005 E. Monument Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Green Mount	June 23 1924
20-UNDERTAKER.	ADDRESS
John Ott & Sons	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

88055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 D 88055

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Prestman ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hunter King Jr

(a) RESIDENCE NO. 3206 Prestman ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/21/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo H King

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura E Sommer

13 BIRTHPLACE OF MOTHER (city or town) Phila.
(State or country) Penna

14 Informant Mother
(Address)

15 JUN 2 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21 1924

17

I HEREBY CERTIFY, That I attended deceased from 6/21, 1924, to 6/21, 1924

that I last saw him alive on 6/21, 1924,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(32 wks fœtus)

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Osborne Reese M. D.

6/23/1924 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	June 23 1924
20 UNDERTAKER	ADDRESS
John O. Mitchell	1200 N. Fayette

Spec. 12-23-21—E.B.R.S.—400 Blks.

D 88056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 S Bond St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Zinz

(a) Residence No. 430 S Bond St Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie Zinz

6-DATE OF BIRTH (month, day and year)

7-AGE. 68 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Furniture

(b) General nature of industry, business, or establishment in which employed (or employer). Merchant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Joseph Zinz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Liba

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Russia

14- (Informant). Edward Zinz

(Address). 430 S. Bond St

15- Filed JUN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 22-24

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 19 20 to June 22 19 24

that I last saw him alive on June 22 19 24

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm F Bruglon M. D.

6/23, 1924 (Address) 210 N Bond

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dolfield Hebrew Rest DATE OF BURIAL. Jun 23 19 24

20-UNDERTAKER. Jack Levin ADDRESS 1439 E Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88057

CERTIFICATE OF DEATH.

3 D 88057

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 939 Pierce ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Marshall

(a) RESIDENCE NO. 939 Pierce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 1905

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18yrs.	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bill Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Kansas.

12 MAIDEN NAME OF MOTHER Stella Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Stella Ross Marshall (Address) 939 Pierce St.

15 JUN 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 1924

17

I HEREBY CERTIFY, That I attended deceased from June 2 1924, to June 25 1924.

that I last saw him alive on June 25 1924.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Bulbar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary TB ?

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. Corbin, M. D.

, 19 (Address) 4 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1924
Mt. Auburn Cemetery	June
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bku.

D 88058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 88058

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 907 Peach ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna Dyson

(a) RESIDENCE NO. 907 Peach ST., 23 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881 Jan 11

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas. Dyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Miss Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Sedona Palmer

(Address) 712 Dolphin St.

15 JUN 23 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 • 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1924, to June 20, 1924, that I last saw her alive on June 19th, 1924, and that death occurred, on the date stated above, at 12:15A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

Int Acute Parenchymatous

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? no.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos Bowley M. D.

6/24/24 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Auburn Cemetery	June 23 1924
20 UNDERTAKER	ADDRESS
Jas Geo H. Hooper	404 W Lombard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

K D 88059

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D 88059

197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Frank.

(a) RESIDENCE NO. 53 S. Carrollton Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------.

6 DATE OF BIRTH (month, day, and year) September 26, 1890.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City
(c) Name of employer Police Department.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W. Frank.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Annie W. Gordon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant George W. Frank. (brother).
(Address) 1045 Hollins Street.

15 JUN 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1924. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis, due to perforation of intestines.
Pistol shot wound
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Homicide (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner) June 23, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	6/23/24
20 UNDERTAKER	ADDRESS
Jno. J. Gulds	1200 N. Gay

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88060

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88060

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 2815 Hartford Ave. 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeannette Elosier

(a) Residence No. 2815 Hartford Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Charles W Elosier

6-DATE OF BIRTH (month, day and year) April 9-1888

7-AGE, 36 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph E. Jenkworthy

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not Known

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Germany

14-

(Informant) Charles W. Elosier

(Address) 2815 Hartford Ave.

JUN 2 31924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21/24

17- I HEREBY CERTIFY, That I attended deceased from Nov 12, 1923, to June 21st, 1924, that I last saw h~~er~~ alive on June 20, 1924, and that death occurred, on the date stated above, at 2 a m. The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) 7 yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 6th 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Pearce, M. D.

June 21, 1924 (Address) 1 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: June 25 1924

20-UNDERTAKER: Jas C Miller

ADDRESS 2334 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 8806 F

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 D 8806 F

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1939 E. Biddle ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina C. Nollmeyer

(a) RESIDENCE No. 1939 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of John G. Nollmeyer

6 DATE OF BIRTH (month, day, and year) Aug. 31 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	69	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank J. Giller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline Rode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John G. Nollmeyer

(Address) 1939 E. Biddle St

JUN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 1924

17 I HEREBY CERTIFY, That I attended deceased from May 1 1924 to June 21 1924, that I last saw h[illegible] alive on June 3 1924, and that death occurred, on the date stated above, at 9.05 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) J. G. Le Compte M. D.

June 23 1924 (Address) 1301 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 25th 1924
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1801 E Eager

Spec.—1-10-21—M&T—1500 Blks.

D 88062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88062

CERTIFICATE OF DEATH.

1291

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 E. Eager ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Marsh

(a) RESIDENCE NO. 1431 E Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salome Marsh

6 DATE OF BIRTH (month, day, and year) Dec. 11 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis (State or country) Md

PARENTS

10 NAME OF FATHER William P. Kilman

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Miss. Maguire

13 BIRTHPLACE OF MOTHER (city or town) Not Kn (State or country)

14 Informant Wm. William K. Marsh (Address) 1431 E Eager St

15 Filed JUN 23 1924 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 19 24

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 , 19 24, to June 22 , 19 24, that I last saw h alive on June 22 19 24, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Abundant Nephritis arterio Sclerosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed djagnosis?

(Signed) Alma B Lemmon M. D.

6/24/1924 (Address) 718 N Pat Pk ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL June 25 19 24

20 UNDERTAKER Henry Hoch Son ADDRESS 1301 E Eager St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88063

CERTIFICATE OF DEATH.

31 D 88063

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: No. 1110 Warner ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alice Snowden

(a) RESIDENCE. No. 1110 Warner ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Snowden

6 DATE OF BIRTH (month, day, and year) Jan 21 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40 yrs.	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co. Md.

PARENTS

10 NAME OF FATHER John A Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Chas A Snowden

(Address) 1110 Warner St

JUN 2 3 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19" 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10" 1924 to June 19" 1924

that I last saw h. alive on June 19" 1924

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza (duration) Abt. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum (+) H.D.Lab.

(Signed) L. T. Hilton, M. D.

6/20/24 (Address) 130 N. Bilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 23 1924

20 UNDERTAKER By John H Toadvine ADDRESS 142 Lytle St

Spec-12-23-21-E.B.R.S.—400 Bks.

D 88064 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 961 N. Chester St., 7 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Baborowsky

(a) Residence No. 961 N. Chester St., ...Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emilie Baborowsky

6-DATE OF BIRTH (month, day and year) Not known

7-AGE. 45 yrs. .....mos. .....ds. If LESS than 1 day, ...hrs. or. .....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Bohemia

PARENTS.

10-NAME OF FATHER, Karel Baborowsky

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bohemia

12-MAIDEN NAME OF MOTHER, Rosie Cerwak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bohemia

14- (Informant) Emilie Baborowsky
(Address) 961 N. Chester and

15- JUN 23 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 21/24

17- I HEREBY CERTIFY, That I attended deceased from March 20 1924, to June 20 1924, that I last saw h.. alive on June 20 1924, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

.....(Duration) .....yrs. 3 mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) William J. Rysavy M.D.

June 21 (Address) 96 N. Chester

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Hill	June 23 1924
20-UNDERTAKER.	ADDRESS
Frank Zvarek & Son	1906 Fleet Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D 88065

17001/2

HEALTH DEPARTMENT—CITY OF BALTIMORE

D/88065

154

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 13 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reva Wilkes

(a) RESIDENCE NO. 2310 McCulloughST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Isaac Wilkes

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair dresser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thos. Harding

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliz. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL.

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1924, to June 21, 1924, that I last saw h[illegible] alive on June 21, 1924, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Pemphigus

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Walter B. Stewart, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cem.

DATE OF BURIAL June 24

UNDERTAKER Samuel Wemsley

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-24—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88066

CERTIFICATE OF DEATH.

3 ✓ D 88066

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 S. Charles St., 23 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbur R. Powers Jr

(a) Residence No. 1733 S. Charles St., 23 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Aug 5, 1920

7-AGE. If LESS than 1 day, ...hrs. or ....min.?

3 yrs. 10 mos. 16 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Wilbur R. Powers Sr

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Wash. D.C.

12-MAIDEN NAME OF MOTHER: Margaret Felthousen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant) Father Wilbur R. Powers Sr

(Address) 1733 S. Charles St

15- JUN 2 31924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 21-1924

17- I HEREBY CERTIFY, That I attended deceased from May 23rd 1924 to June 21- 1924

that I last saw h... alive on June 21- 1924

and that death occurred, on the date stated above, at 12- m.

THE CAUSE OF DEATH* was as follows: Tuberculosis Meningitis

(Duration) yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of Autopsy

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) A. Howard Evans M. D.

, 19 (Address) 1340 S Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: June 24 1924

20-UNDERTAKER: A. Howard Evans — ADDRESS: 38 S Port Ave

Spec.—1-10-21—M&T—1500 Blks.

D 88067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88067

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 N Spring ST., 9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Taylor

(a) RESIDENCE NO. 1837 N Spring ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ..... mos.

How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (~~HUSBAND~~ or) WIFE of William Taylor

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	approx 54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Wm Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susie Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Hattie Stewart 1919 N Spring St

JUN 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1924

17 I HEREBY CERTIFY, That I attended deceased from March, 1924, to June 20, 1924, that I last saw h[er] alive on June 19, 1924, and that death occurred, on the date stated above, at 11 45 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemmorhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R Saunders, M. D.

6/23, 1924 (Address) 1429 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 25 1924
20 UNDERTAKER	ADDRESS
Jere R A Elliott	1725 Ashland Av

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88068

CERTIFICATE OF DEATH.

D 88068

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hosp. St., 2517 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Hurt

(a) Residence No. 2121 Market St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ludwig Hurt

6-DATE OF BIRTH (month, day and year) May 5-1891

7-AGE 33 yrs. 1 mos. 15 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bottle Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Factory

(c) Name of employer

9-BIRTHPLACE (city or town) Md

(State or Country)

PARENTS.

10-NAME OF FATHER (Deceased) Fredrick Wilson

11-BIRTHPLACE OF FATHER (city or town) Germany

(State or Country)

12-MAIDEN NAME OF MOTHER, Caroline Ludwig

13-BIRTHPLACE OF MOTHER (city or town) Germany

(State or Country)

11- (Informant) Mrs. Caroline Hurt

(Address) 2121 Market St

15- JUN 23 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-20-24

17- 6-6- I HEREBY CERTIFY, That I attended deceased from ..... 1924 to 6-20 1924

that I last saw h... alive on 6-20 1924

and that death occurred, on the date stated above, at 7 45 P.M.

The CAUSE OF DEATH* was as follows:

Acute anterior Polio-encephalitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? (No)

What test confirmed diagnosis? Physical Exam

(Signed) H. Harper, M. D

, 19 (Address) Glaquestaup.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, June 23, 1924
UNDERTAKER	ADDRESS

Loudon Park George Johnson Co. Eutaw & Lombard Sts.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88069

HEALTH DEPARTMENT—CITY OF BALTIMORE

88069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward) 161-09

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Liebl

(a) Residence No. Edmondson & Buchanan Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 22, 1924

7-AGE. yrs. mos. ds.

If LESS than 1 day, 7 hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James Liebl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Maryland.

12-MAIDEN NAME OF MOTHER, Mable E. Henning

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore, Maryland.

14-(Informant) James Liebl

(Address) Edmondson & Buchanan

15-

Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-22-24

17- I HEREBY CERTIFY, That I attended deceased from 6-22- 1924, to 6-22 1924

that I last saw him alive on 6-22 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) yrs. mos. 2 hrs. ds.

CONTRIBUTORY (Secondary) Acute Hydramnios

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

6/22 1924 (Signed) H V Harper M. D

(Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, June 23 1924
20-UNDERTAKER, Joseph B Cook	ADDRESS 1003 N Bath St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

Register No. D 88070

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enoch Lisle

(a) Residence No. Edmondson & Buchanan St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 6-22-24

7-AGE: yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: James Lisle

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Maryland

12-MAIDEN NAME OF MOTHER: Mabel E. Henning

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Maryland.

11- (Informant) James Lisle

(Address) Edmondson & Buchanan

15- JUN 23 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6-22-24

17- I HEREBY CERTIFY, That I attended deceased from 6-22-24, 19..., to 6-22, 19 24

that I last saw h.. alive on 6-22, 19...

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) 2 hrs of life yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Hydramnios

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

6/22, 1924 (Signed) H W Hopper M. D

(Address) St Agnes Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, June 23" 24
New Cathedral Cem	
20-UNDERTAKER, Joseph B. Cook	ADDRESS 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88071

Marie Clarke

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 88071

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Clark

(a) RESIDENCE NO. 418 N. Greene Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Glenn Clarke

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Lena Grand Shaw

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs. Glenn Clark (Address) 418 N. Greene St

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 23, 1924, that I last saw her alive on June 23, 1924, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Adenitis, Congenital Lues.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jay Martin, M. D.

6/23, 1924 (Address) Union memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Clark Cem	June 24 1924
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Dallas St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88072

CERTIFICATE OF DEATH.

51 D 88072

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. ST., 26 WARD)

2-FULL NAME Jessie Martell

(a) RESIDENCE No. 311 S. 13rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	23	5	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER Alexander Martell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Lena Adams.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md.

14 Informant Alexander Martell
(Address) 311 S. 13th St

15 Filed JUN 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1924, to June 21 1924.

that I last saw he alive on June 21, 1924,

and that death occurred, on the date stated above, at 6½ P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mc. Endocarditis ac.

Rheumatic fever (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 311 S. 13th St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo B. Dyberry M. D.

, 19 (Address) St Joo. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem,	June 24 1924
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403½ N Mt Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 88073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 88073

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1930 Lemden Ave ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John K. Mcginnis

(a) RESIDENCE. No. 1930 Lemden Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary E. Mcginnis

6 DATE OF BIRTH (month, day, and year) April 27, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturers Representative

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) Bath
(State or country)

PARENTS

10 NAME OF FATHER James K. Mcginnis

11 BIRTHPLACE OF FATHER (city or town) Bath
(State or country)

12 MAIDEN NAME OF MOTHER Margaret A. Martin

13 BIRTHPLACE OF MOTHER (city or town) Bath
(State or country)

14 Informant Henry J. Mcginnis
(Address) 1936 Lemden Ave

15 JUN 23 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1924

17 I HEREBY CERTIFY, That I attended deceased from ... 19..., to June 22, 19 24,

that I last saw h... alive on June 21, 19 24,

and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene
Hardening of the Arteries

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Krauter, M. D.

, 19 (Address) 1536 Lemden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 24 1924
20 UNDERTAKER George J. Smith	ADDRESS 153 E Hollins

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88074

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 608 S Kenwood Ave Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna J. Mariner

(a) Residence No. 608 S Kenwood Ave St., Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feby 15-1900

7-AGE, 24 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Office work

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Spring Valley Va

PARENTS.

10-NAME OF FATHER, Wm E Mariner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Spring Valley Va

12-MAIDEN NAME OF MOTHER Sarah A Robinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Dorothy M Wade

(Address) 608 S Kenwood Ave

JUN 2 3 1924

Filed, 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 22-24

17- I HEREBY CERTIFY, That I attended deceased from June 4 19 24 to June 21-24

that I last saw her alive on June 14-1924

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilateral

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick W Hermans M. D.

(Address) 1913 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Franklin City Va	June 24-24
20-UNDERTAKER,	ADDRESS
Robt J Inman Jr	148 N Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88075 ✓ 164 D 88075

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Liberty Heights St., 45 WARD)

2-FULL NAME Etta Grollman

(a) RESIDENCE NO. 2408 Liberty Heights ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isaac Grollman
(Address) 2408 Liberty Heights

15 JUN 2 1924 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-14, 1924, to 6-22-, 1924.
that I last saw h alive on 6-22-, 1924
and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

General Debility

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Harry Goldberg M. D.
6/23, 1924 (Address) 2210 Entaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Park	6/23, 1924
20 UNDERTAKER	ADDRESS
Sol Levinson & Bro	E Balto St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN2

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88076

CERTIFICATE OF DEATH.

100-001 V

D 88076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 1/2 E 8th St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George P Lucas Jr.

(a) RESIDENCE NO. 1914 1/2 E. 8th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 22nd 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Ponzetti Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma P Noble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) George P Lucas, 1914 E 8th St

15 3 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/ 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 22, 1924, that I last saw him alive on June 22, 1924, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.M. & Symptoms

(Signed) Thomas F Mackie M. D.

, 19 (Address) 451 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Vincents Cemetery

DATE OF BURIAL June 24th 1924

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E Monument St

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88077 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88077

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 East 22nd St., 9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hammond Cromwell Brown

(a) RESIDENCE No. 536 East 22nd St., 9th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
~~Male~~	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 5th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John B Brown

11 BIRTHPLACE OF FATHER (city or town) Centreville (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Gemmill

13 BIRTHPLACE OF MOTHER (city or town) Kent County (State or country) Maryland

14 Informant Mrs C. H. Cromwell (Address) Edmondson City Md

JUN 23 1924 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to June 23, 1924.

That I last saw him alive on June 23, 1924;

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Accidents. - 24 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Carroll Lockard, M. D.

June 23 1924 (Address) 4 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Johns Cemetery Howard Co	June 24 1924
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Co	Ordered 4 W. Eutaw St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88078 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88078

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1715 Ebling Ct St., V Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James J. Archer

(Residence in Baltimore: No. 1715 Ebling Ct St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. March 9 (Month) (Day) 1914 (Year)

7-AGE. 9 yrs. 3 mos. 12 ds. If LESS than 1 day, hrs. or mlu.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General natuie of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. John Archer

11-BIRTHPLACE OF FATHER, (State or Country). Harford Co

12-MAIDEN NAME OF MOTHER. Annie Tyler

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Archer

(Address) 1715 Ebling Ct

15- FILED JUN 23 1924 192.. Robert P. Harrison, Registrar.

Burial Permit Clerk

1585

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 21 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Hanlon M. D. (Coroner)

June 21 192 4 (Address) 700 E. Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. JUN 23 1924

20-UNDERTAKER.

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88079

CERTIFICATE OF DEATH.

X 38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Irby Hayden

(a) Residence No. Mt Hope Retreat St., 28a Ward Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Hayden

6-DATE OF BIRTH (month, day and year) 12 May 1895

7-AGE, 29 yrs. 0 mos. 0 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Norfolk (State or Country), Va

PARENTS.

10-NAME OF FATHER, James R. Irby

11-BIRTHPLACE OF FATHER (city or town) Norfolk (State or Country), Va

12-MAIDEN NAME OF MOTHER, Lillie O'Donnell

13-BIRTHPLACE OF MOTHER (city or town) Charleston (State or Country), S. C.

14- (Informant) Records of Mt Hope Retreat

(Address) Baltimore Md

15- 2nd 19 Robert P. Harrison, Registrar.

JUN 23 1924

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 22 - 24

17- I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to June 22, 1924, that I last saw h. alive on June 22, 1924, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Paresis (Lunatic)

abt (Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Paralytic Dysentery

abt (Duration) 1 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Norfolk Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Hammers, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL, 6/24/24

20-UNDERTAKER John J. Lahey ADDRESS 318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

S.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DURATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 88080

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88080

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 McElderry ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Burns

(a) RESIDENCE. NO. 1241 McElderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F. Fmale	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Burns

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant (Address) James A. Burns 1241 McElderry St

15 FILED JUN 23 1924 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 21, 1924, that I last saw h[illegible] alive on June 21, 1924, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Green, M. D.

6-23, 1924 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	June 24 '24

20 UNDERTAKER Mrs J. D. Locke ADDRESS 1302 Jeffers

Size—12-23-21—E B R S.—400 Bks.

D 8808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8808

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 809 McDonough St

Registered No.....

City of BALTIMORE: (No. 809 McDonough St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rachel A. Grass

(a) Residence No. 809 McDonough St., 7 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of George Grass.

6-DATE OF BIRTH (month, day and year) June 10 1890

7-AGE. 34 yrs. 10 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER Charles Duvall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore, Md

12-MAIDEN NAME OF MOTHER, Frances Howard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) George Grass, Husband

(Address) 809 McDonough St

15- June 23 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

JUN 23 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 20, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 14, 1924 to June 20, 1924

that I last saw her alive on June 20, 1924

and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. 3 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) yrs. mos. 3 4 ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological and Clinical

(Signed) Neil D. Macdonald M. D.

June 20, 1924 (Address) 1540 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Asbury Cem. DATE OF BURIAL. June 24 1924

20-UNDERTAKER. Mrs J. G. Locks ADDRESS 352 Jefferson

18.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 88082

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88082

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W. Moore.

(a) RESIDENCE NO 1157 Gorsuch Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Henry B. Berry.
(Address) 1157 Gorsuch Ave.

15 Filed JUN 23 1924 192 Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June 23, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?
Marine Hotel. June 21, 1924.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 6/25/24 1924

20 UNDERTAKER Wm Cook — ADDRESS 302 E N

Daniel Permit Clerk

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88083

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. Mount Hope Retreat St., 2[illegible] Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Agnes Ryan

(a) Residence No. Mount Hope Retreat St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1860

7-AGE.	If LESS than 1 day,
64 yrs. 0 mos. 0 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Michael Ryan

11-BIRTHPLACE OF FATHER (city or town) (?) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Morris

13-BIRTHPLACE OF MOTHER (city or town) (?) (State or Country), Ireland

11- (Informant) R. Curran 27 Mt. Hope Retreat

(Address) Mt. Hope Balto Md.

15- JN 2 31924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 23-24

17- I HEREBY CERTIFY, That I attended deceased from Apl 18th 1898., to June 23 19 24, that I last saw h. alive on June 23, 19 24, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

abt 1 year

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Delusional Psychosis

abt (Duration) 24 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 6-24 1924
Cathedral	
20-UNDERTAKER, Wallace Cook	ADDRESS 502 E Nav

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88084

CERTIFICATE OF DEATH.

D 88084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3306 Fairview Ave. WARD) 20

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah A. Challis

(a) RESIDENCE. No. 3306 Fairview Ave. ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry E. Challis

6 DATE OF BIRTH (month, day, and year): July 2 - 1840

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Howard Co Md

PARENTS

10 NAME OF FATHER: Enoch Selby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hazzy E. Challis
(Address): 3306 Fairview Ave

15 Filed ... 19... Robert P. Harrison, Registrar

JUN 23 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1923, to June 22, 1924, that I last saw h.er alive on June 22, 1924, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 2+ yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry T. Collenberg, M. D.

6/23, 1924 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Montview Howard Co Md	June 25 1924
20 UNDERTAKER	ADDRESS
John O Mitchell	1201 W Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88085

CERTIFICATE OF DEATH.

D 88085

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 N. Carey St.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse Albert Thatcher

(Residence in Baltimore: No. 117 N. Carey St.; Life yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Feby (Month) 23 (Day), 1856 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Post Office
(b) General nature of industry, business, or establishment in which employed (or employer): Asst Supt.

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Jesse R. Thatcher

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Matilda Daniels

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas C. Thatcher

(Address) Baltimore Apts

15-

Filed ..... Robert P. Harrison, Registrar.

JUN 2 31924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 25 1924, to June 22 1924, that I saw h[e] alive on June 22 1924, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Debility

(Duration) ..... yrs. ..... mos. 28 ds.

(Signed) R. G. Davis M. D.

June 23, 1924 (Address) 1509 N. Carlton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, June 24th, 1924

20-UNDERTAKER John O. Mitchell ADDRESS 320 W Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's certificate of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88086

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88086

CERTIFICATE OF DEATH.

118-09

1-PLACE OF DEATH Mt Gen Hospl.

CITY OF BALTIMORE: (No. 1100 Ida Lewis ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 1020 Lindman

(a) RESIDENCE NO. Balto Md WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of)

6 DATE OF BIRTH (month, day, and year) Dec. 19 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER R S Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mildred Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Mrs Lewis 1020 Linden Ave

15 Filed . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

JUN 23 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.22.24

17 I HEREBY CERTIFY, That I attended deceased from 6.13.24, 19 . to 6.22.24. 19 ,

that I last saw her alive on 6.22.24 19 ,

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Partial Paralysis Cerebral Hemorrhage

Duration

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Young M. D.

. 19 (Address) Mt Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Culpeper Va

DATE OF BURIAL June 24 19 24

20 UNDERTAKER Harry H. Woltz & Co

ADDRESS

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88087

CERTIFICATE OF DEATH.

88 D 88087

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

amanda

2-FULL NAME Amanda Crane

(a) RESIDENCE NO. 1046 Williams St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William G. Crane

6 DATE OF BIRTH (month, day, and year) unknown 1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Hartenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Gunther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant William G. Crane
(Address) 1046 William St.

15 JUN 23 1924 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from 4-21-, 1924, to 6-23-, 1924, that I last saw her alive on June 23, 1924, and that death occurred, on the date stated above, at 3:00 P.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
Streptococcus Septicemia

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings.

(Signed) ..... M. D.

, 19 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 26 1924
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light St.

Cor.—1-12-23—M&T—100 Bks.

D 88088

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88088

CERTIFICATE OF DEATH.

188-003

23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST. Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David L. Smith.

(a) RESIDENCE No. 1833 Hanover St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 4 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 24, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	4	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Harry H. Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Florence Bahlein.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Harry H. Smith. (father)
(Address) 1833 Hanover St.

15 Filed ....., 192 Robert P. Harrison,
Registrar
Burial Permit Clerk

JUN 2 3 1924

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally struck and knocked down by an automobile while crossing the street. Fracture of skull.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Traumatic Meningitis.

(duration) yrs. mos. 2 ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

June, 23, 1924 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL June 25 1924

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be ... See instructions on back of certificate. ... TION is very important.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88089

CERTIFICATE OF DEATH.

D 88089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St. 15 WARD)

REGISTERED NO. 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Clare Lungan

(a) RESIDENCE NO. 1718 Warwick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Francis

6 DATE OF BIRTH (month, day, and year) Feb 22-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Hesse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Klatz

(Address) 178 Warwick

JUN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1924, to June 20, 1924.

that I last saw h[illegible] alive on June 20, 1924,

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Acute Cardiac Dilatation
Heat Exhaustion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cholecystitis + Cholelithiasis
Chr. Appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1718 Warwick ave.

Did an operation precede death? Yes Date of 6/20/24

Was there an autopsy? No.

What test confirmed diagnosis Physical Evidence

(Signed) Geo B Sybert, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL June 27 '24

20 UNDERTAKER Martin Tierney Son — ADDRESS 1717 W North

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88090

49 D 88090

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 846 Edmondson Av ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Marie Porteous

(a) RESIDENCE. No. 846 Edmondson Av St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: David Porteous

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Margaret Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Alice Porteous
(Address): 846 Edmondson Avenue

15 Filed JUN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to June 21, 1924, that I last saw h.. alive on June 21, 1924, and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder
uretha Metastasis to bone
+ probably to spine

.....(duration) 4 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Karl Steinmueller, M. D.

6/27, 1924 (Address) 207 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/24 1924
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son 805	N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88091 — CERTIFICATE OF DEATH. — D 88091

80-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, 17 WARD)

2-FULL NAME William D. Stewart

(a) RESIDENCE NO. 541 Prestman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colb	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): March 27/2[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wm. Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Angea London

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Angea Stewart
(Address): ~~541 Prestman~~

15 Filed ..... 1924 ROBERT R. KRAUTER, Registrar
JUN 24 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Otitis Media -Ricketts

(Autopsy At Hospital)

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Mc Cullough, M. D. (Coroner)

6/23/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Bur — DATE OF BURIAL: 6/24 192 24

20 UNDERTAKER: Daniel Easton — ADDRESS: 9/6 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88092

CERTIFICATE OF DEATH.

X 101-001 D 88092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Marshall

(a) RESIDENCE No 914 McDonough ST., WARD North Carolina

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec 14/23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Thomas Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Bradford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mrs. R.A.Elliott
(Address) 1925 Ashland ave.

15 Filed ....., 192 ..... Registrar

JUN 24 1924 ROBERT R. KRAUTER, Clerk Circuit Court

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 28 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Collins, M. D.
(Coroner)

June 23/24 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 24/24
20 UNDERTAKER Mrs R.A. Elliott	ADDRESS 1925 Ashland av

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88093

CERTIFICATE OF DEATH.

129 D 88093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1911 aisquith ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME clara Stanton

(a) RESIDENCE NO. 1911 aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 10 March 1908

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
16	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Georges Flyn

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Warner Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Smith

(Address) 1911 Augusta St.

15 Filed JUN 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1924

17 I HEREBY CERTIFY, That I attended deceased from 10 June 1924 to 22 June 1924.

that I last saw h[illegible] alive on 21 June 1924,

and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Mitral & aortic Insufficiency

nephritis, etc. (Organic)

(duration) several yrs. — mos — ds.

CONTRIBUTORY (Secondary) Uremia, Heart failure several weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Idonot Knows.

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? [illegible]

(Signed) Mayfield Boyd M. D.

7/16 19 24 (Address) 420 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 24 1924
20 UNDERTAKER	ADDRESS
Mrs R. A. Elliott	220 Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88094

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1513 Marshall St. St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Russell Giffin

(a) Residence No. 1513 Marshall St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (write word)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah V. Giffin

6-DATE OF BIRTH (month, day and year) Mar. 27 1863

7-AGE. 61 yrs. 2 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Molder

(b) General nature of industry, business, or establishment in which employed (or employer) Car works

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Tennesee

PARENTS.

10-NAME OF FATHER, William Giffin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Tennesee

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

11- (Informant) Mrs. Sarah V. Giffin

(Address) 1513 Marshall St.

15- JUN 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 23 1924

17- I HEREBY CERTIFY, That I attended deceased from Nov. 24 1923 June 23 1924

that I last saw him alive on June 22 1924

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows: Hodgkins Disease

(Duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physicians Present

What test confirmed diagnosis?

(Signed) A. Phillips Sly M. D.

, 19 (Address) 1340 A Aisquith

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Knoxville Tenn.	June 25 19
20-UNDERTAKER.	**ADDRESS**
L. Fenn McCully	130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D 88095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 D 88095

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Maer

(a) RESIDENCE. No. Bay View asylum ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/24/1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Fred Maer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed JUN 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21-1924

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1924, to 6-21, 1924

that I last saw him alive on 6-23, 1924

and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3-4 ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sct.

(Signed) Claude G. Drane, M. D.

6-23 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 6/24 1924

20 UNDERTAKER: George J. Ruth — ADDRESS: 1738 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1800 Mks.

1052 88096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

86005 D 88096

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

2-FULL NAME John Thomas

(a) RESIDENCE No. 5th Imment Dof Aug ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Life mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1923

7 AGE Years — Months 6 Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JUN 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1924

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1924, to June 22, 1924, that I last saw him alive on June 22, 1924, and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Undernutrition — 4-5 mos.

Otitis media (bilateral) — 3 mos. +

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Mastoiditis (bilateral)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? St Vincents Inf. Asy.

Did an operation precede death? Yes. Date of June 20

Was there an autopsy? Yes.

What test confirmed diagnosis? —

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 6/24 1924

20 UNDERTAKER George J Ruth

ADDRESS 1733 Harford Av

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88097

CERTIFICATE OF DEATH.

90

D 88097

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1207 E Madison St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha L Webber

(a) Residence No. 1207 E Madison St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Thomas Webber

6-DATE OF BIRTH (month, day and year) Don't Know.

7-AGE. 79 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Francis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hayford Md

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) Lillian M Smyth

(Address) 3832 Old Frankford

15-Filed JUN 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21-1924

17- I HEREBY CERTIFY, That I attended deceased from Mar 8 19 24 to June 21 19 24

that I last saw h alive on June 21 19 24

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) about 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W A Fair M. D.

6/22 1924 (Address) 12 E 25th St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. June 23 1924

20-UNDERTAKER. J Welch

ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88098

CERTIFICATE OF DEATH.

x 73 D 88098

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9 WARD)

2-FULL NAME George Schultz

(a) RESIDENCE NO. Middle River ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. 13 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 28, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	42	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Sheriff 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John P. Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Eva Fischer

(Address) 1714 E. Preston St

15 JUN 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 23, 1924.

That I last saw him alive on June 23, 1924,

and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Transverse Myelitis

(duration) yrs. 6 mos. (Paralysis)

18 Where was disease contracted if not at place of death? Middle River

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Dyberk, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL June 25 1924

20 UNDERTAKER Mrs. Mrs. John W. Teufel & Son — ADDRESS 801 W. Fayette

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88099

CERTIFICATE OF DEATH.

74 D 88099

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 121 So. Calhoun St (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank C. Neber

(a) RESIDENCE NO. 121 So. Calhoun St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C. Neber

6 DATE OF BIRTH (month, day, and year) Nov. 9 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bartlett, Hayward Co

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Neber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant James R. Weber
(Address) 1612 E. 32 St. Balto.

15 Filed JUN 24 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, I find that said deceased came to ... death on the day stated above.
(autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. P. Morrow, M. D.

(Coroner)

June 23rd, 1924 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury; (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional directions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 25 1924

20 UNDERTAKER John J. Fields ADDRESS 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-2007 D 88100

D 88100

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3607 Windsor Mill Road 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Leckler Tapley.

(a) Residence No. 3607 Windsor Mill Rd. St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Leonard Tapley

6-DATE OF BIRTH (month, day and year) Dec 2 1872

7-AGE. 51 yrs. 6 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Lancaster Co Penna

PARENTS.

10-NAME OF FATHER Edward A. Leckler

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lancaster Co Penna

12-MAIDEN NAME OF MOTHER Hannah Bitger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lancaster Co Penna

14-INFORMANT. (Informant) Leonard Tapley

(Address) 3607 Windsor Mill Rd

15-FILED JUN 24 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 — 1923 to June 21 1924

that I last saw her alive on June 20 1924

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (Hypertension Neph.) (Alcoholic Neph.)

Hypostasis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis and ascites (Duration) 6 yrs. mos. + ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan: Exploratory

Was there an autopsy? No

What test confirmed diagnosis? Operation and Laboratory

(Signed) Wesley Cole M. D.

6/23. 1924 (Address) 2 E Raymond

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. June 24th 1924

20-UNDERTAKER. Wm J. Dickey & Sons ADDRESS No. Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 ✓

D 88101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 108 (ST.) Gibbons Ave (WARD) 27

2-FULL NAME Mrs Caroline Fensuer

(a) RESIDENCE NO. 108 Gibbons Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Louis F Fensuer

6 DATE OF BIRTH (month, day, and year) Oct. 29 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pennsylvania

PARENTS

10 NAME OF FATHER David Brumm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Yoast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louis F Fensuer (Address) 108 Gibbons Ave

15 Filed JUN 24 1924, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17

I HEREBY CERTIFY, That I attended deceased from Feb 12, 1924, to June 21, 1924.

That I last saw her alive on June 14, 1924,

and that death occurred, on the date stated above, at 12-45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Pylorus Orifice of the Stomach.

To My Knowledge (duration) yrs. 4 mos 9 ds.

CONTRIBUTORY (Secondary) Dilatation of the Stomach (duration) yrs. 4 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? X Ray

What test confirmed diagnosis? Physical Symptoms

(Signed) Francis A Carpenter M. D.

, 19 (Address) 2101 Madison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 24, 24

20 UNDERTAKER Wm. J. Tickner & Sons — ADDRESS N. Y. Pa.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88102

D 88102

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 229 N Chester ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Shanbery

(a) RESIDENCE No. 229 N Chester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1429 E Baltimore St

15 Filed JUN 25 1924, 19.. ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1924, to June 23, 1924,

that I last saw h[illegible] alive on June 23, 1924,

and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Baylus, M. D.

6/25 1924 (Address) 210 N Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/26 1924

20 UNDERTAKER Jack Lewis

ADDRESS 1429 E Balto

Spec.—1-10-21—M&T—1500 Blks.

172465 D 88103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 88103

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Benjamin Bayer

(a) RESIDENCE No. 443 Druid Hill Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Perry Bayer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliz Lotthouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 JUN 24 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1924

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1924, to June 22, 1924, that I last saw him alive on June 22, 1924, and that death occurred, on the date stated above, at 6 50 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver, Leukemia

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary): (Secondary Anemia Syphilis (Wass)) Paralysis Legs

(duration) ½ yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. Austin Pearce M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 6/25 1924

20 UNDERTAKER: John A. Toadvine

ADDRESS 1412 Lisbon St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARY JANE SMITH

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88104 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 172 Dolphin St. Balto; ST.; 11 WARD)

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Smith

(a) RESIDENCE. No. 172 Dolphin St Balto ST., 11 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. X mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Black	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Jan, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	X	

8 OCCUPATIDN OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) Home work Odd

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Nathaniel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant Alberta Ford (Address) 172 Dolphin St Balto Md

15 Filed JUN 24 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1924

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 . 1924 . to June 22 . 1924 .

that I last saw her alive on June 20 . 1924 .

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (over)

(duration) X yrs. 5 mos. 20 ds.

CONTRIBUTORY (Secondary) General debility

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 172 Dolphin St Balto Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) H. Ag Bauman, M. D.

June 23 1924 (Address) 6010 York Road Balto Md

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Hill Baltimore Md	June 24 1924
20 UNDERTAKER Bal- Samuel Hampy	ADDRESS Balto Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88105

CERTIFICATE OF DEATH.

D 88105

REGISTERED NO. 15 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 N. North Av St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence B. Spencer

(a) RESIDENCE NO. 2117 N. North Av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Allen D. Spencer Jr

6 DATE OF BIRTH (month, day, and year) Oct 16 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas E. Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Maryland

12 MAIDEN NAME OF MOTHER Sarah Harlton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Allen D. Spencer Jrs

(Address) 2117 N. North ave

15 JUN 24 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1924, to June 22nd, 1924.

that I last saw h[illegible] alive on June 22nd, 1924

and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Complete motor paralysis of right side

(Signed) [illegible] M. D.

6/22/1924 (Address) Walbrook Ave 3402.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL June 24 1924

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

~~D 38106~~ HEALTH DEPARTMENT—CITY OF BALTIMORE D 88106

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO. 129

CITY OF BALTIMORE: (No. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Gaines

(a) RESIDENCE NO. 1622 McCulloh St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	-		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER R. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Betsy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1924 to June 21, 1924.

that I last saw her alive on June 21, 1924

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Ac bronchopneumonia

(duration) yrs. mos. 3-4 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Lawrence Wilson M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Auburn Cem DATE OF BURIAL 6-23-24

20 UNDERTAKER Helen A. Holland ADDRESS 1631 Druid Hill Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88107

CERTIFICATE OF DEATH.

31 D 88107

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2340 Mace St., 17 WARD)

2-FULL NAME Francis Cole

(a) RESIDENCE NO. 2340 Mace St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Cole

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Elena Cole Wife

(Address) 2340 Mace St

15 JUN 24 1924 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1924

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1924 to June 21, 1924.

that I last saw ~~him~~ alive on June 21, 1924.

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Phthisis

(duration) yrs ~~apx~~ 2 ds.

CONTRIBUTORY (Secondary) Cardiac Effusion

(duration) yrs. ? mos. 9 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? ~~yes~~ Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Wm Lydell, M. D.

, 19 (Address) 926 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 24, 24
20 UNDERTAKER	ADDRESS
Wm R. Elliott	1725 Eutaw

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D 88108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 Laurens ST. 14 WARD)

2-FULL NAME Augusta Rodgers

(a) RESIDENCE. No. 420 Laurens ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs — mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur Rodgers

6 DATE OF BIRTH (month, day, and year) Nov 27 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Ann Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mamie Owens

(Address) 420 Laurens St

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

JUN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21- 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-18-, 1924, to 6-21-, 1924

that I last saw her alive on 6-21-, 1924.

and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(duration) yrs. few months mos. ds.

CONTRIBUTORY (Secondary) Cardio Ghastritis (Contributory) Edema

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 420 Laurens

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W K Bowkin, M. D.

19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
WM Auburn	June 24 1924

20 UNDERTAKER Franklin & Sons ADDRESS 709 W. Fayette St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88109

CERTIFICATE OF DEATH.

74 D 88109

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 726 School St ST. 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Lucas

(Residence in Baltimore: No. 726 School St

St.: (yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	colored	widow

6-DATE OF BIRTH, Unknown (Month) ..... (Day), 1868 (Year)

7-AGE, 56 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Robinson

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margaret Grayson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Iva Brown

(Address) 726 School St

15-

Filed JUN 24 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 23, 1924

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessey M. D.
(Coroner.)

June 24, 1924 (Address) 2802 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... d

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Prince Bros Cemetery

DATE OF BURIAL June 25 1924

20-UNDERTAKER Prince & Wright

ADDRESS 1364 Mary

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88110 — 124 — D 88110

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1389 Woodyear St.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Ann Jolly

(a) RESIDENCE. No. 1389 Woodyear St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Jolly — 1855

6 DATE OF BIRTH (month, day, and year) June 25 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Robert Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Eliza Grace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Clarence Fen Mollock (Address) 1389 Woodyear St

15 Filed ..... 19 ROBERT R. KRAUSER Registrar

JUN 24 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1924 to June 23, 1924, that I last saw h.. alive on June 23, 1924, and that death occurred, on the date stated above, at 9.50 A. p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? 1389 Woodyear

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H. Wright M. D.

June 20, 1924 (Address) 1209 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	June 26 1924

20 UNDERTAKER Clarence E. Wright ADDRESS 1364 Carey

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D 88111

CERTIFICATE OF DEATH.

D 88111

1-PLACE OF DEATH

City of BALTIMORE. (No. Maryland General Hosp. St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Rose Goldberg Eichner

(a) Residence No. 902 N. Eden St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 17 1857.

7-AGE. 67 yrs. mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Retired

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Jacob Eichner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Amelia Reid.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Pauline Fuchs

(Address). 902 N. Eden St.

15- Filed JUN 24 1924 ROBERT R. KRAUTER Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 22 1924.

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1924 to June 22 1924

that I last saw him alive on June 22 1924

and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Pyrexia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos 23 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? See over Date of

Was there an autopsy? None

What test confirmed diagnosis? Blood culture

(Signed) H. A. Bowlen M. D.

6/27, 1924 (Address) 617 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL, June 25, 1924

20-UNDERTAKER. Freeman. ADDRESS 324 Broadway.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88112

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 D 88112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Municipal Hospital St.: 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Romanoski

(a) RESIDENCE. No. 602 S. Patterson Park St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wm Rocnaki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 24 1924 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-14, 1924, to 6-23, 1924

that I last saw her alive on 6-22, 1924

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration
Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Dean, M. D.

6-23, 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem,	June 26 1924

20 UNDERTAKER Kendall Appel ADDRESS 378 N

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1729 D 88113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 250 S. Bond ST.; 3rd WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes J. Magee

(a) RESIDENCE. No. 250 S. Bond ST., 3rd WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry B. Magee

6 DATE OF BIRTH (month, day, and year) Aug. 8- 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D C. (State or country)

PARENTS

10 NAME OF FATHER Patrick Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Bride

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Harry B. Magee

(Address) 250 S. Bond St

15 Filed JUN 24 1924 19.. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-24- 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2 1924, to June 24, 1924, that I last saw her alive on June 24, 1924, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis & examination

(Signed) A. P. Palmisano, M. D

19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	June 27 24
20 UNDERTAKER	ADDRESS
Wendell Wyatt & Son	375 N

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88114

D 88114

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2225 Orem ave ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis H. Poston

(Residence in Baltimore: No. 2225 Orem ave St.; Life yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 27 (Day), 1884 (Year)

7-AGE, 40 yrs. 11 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Talbot Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 1880

9-BIRTHPLACE, (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Daniel T. Poston

11-BIRTHPLACE OF FATHER (State or Country): New York

12-MAIDEN NAME OF MOTHER: Mary Frederick

13-BIRTHPLACE OF MOTHER (State or Country): Frederick Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose F. Poston

(Address) 2225 Orem ave

15-

JUN 24 1924

Robert P. Harrison,
Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 23 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19. 1924, to June 23 1924, that I saw h[illegible] alive on June 23, 1924, and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(Duration) ....yrs. ....mos. 1 ds.

(Signed) Benj. S. Hayden M. D.

June 24, 1924 (Address) 716 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, June 26 1924

20-UNDERTAKER Richard F. Curley

ADDRESS 1108 Guilford ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88115

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St.: N Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Henderson

(a) RESIDENCE. No. Bay View Asylum St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 24 1924 Robert P. Harrison, Registrar
1543
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 192X

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 192X to 6-22, 192X
that I last saw him alive on 6-22, 192X
and that death occurred, on the date stated above, at 3.30 P. m.
The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sub.

(Signed) Claude S. Dorsey, M. D.

6-23 192X (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS JUN 24 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88116

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Carroll St. Brooklyn St., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James W. Jenkins. (C)

(a) RESIDENCE NO 502 Carroll St. Brooklyn St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Married.

5a If married, widowed or divorced
HUSBAND of (~~WIFE~~) Bertha Jenkins. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	45	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Bertha Jenkins. (C) wife.
(Address) 502 Carroll St. Brooklyn.

15 Filed JUN 24 1924, 192 Robert F. Harrison, Registrar

1540

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June, 23, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL D. JUN 24 1924, 192

20 UNDERTAKER — ADDRESS

JUN 24 1924

Registrar of Vital Statistics

Deputy Clerk

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

UN 24 1924

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88117.

CERTIFICATE OF DEATH.

160 D 88117.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Bowers Ct. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Gaines

(a) RESIDENCE No. 222 Bowers Ct ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

THIS IS A PERMANENT RECORD. Every item must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by law to report promptly to the Health Department all cases coming under their care. Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is necessary. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTAGIOUS DISEASES should be made. Omission to state the time required by law renders physician liable to a penalty. Write plainly, with unfading ink—

MARGIN RESERVED FOR BINDING

NK—THIS IS A PERMANENT REC
GE should be stated EXACTLY.
t it may be properly classified. F
on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See Instructions on b

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Spec.—1-10-21—M&T—1500 Bks.

17 d 6 53 88118

HEALTH DEPARTMENT—CITY OF BALTIMORE D 88118

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank L. Winchester

(a) RESIDENCE NO. Cambridge Springs WARD Cambridge Springs Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 12 ds. How long in U. S., if of foreign birth? 64 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ——— 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Frank Winchester

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Mable Wightman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 24 1924, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1924, to June 23, 1924, that I last saw him alive on June 23, 1924, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Prostatic Hypertrophy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Angina pectoris) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Cambridge Springs Pa

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Anatomical Examination

(Signed) Robert [illegible], M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Springs - Pa.

DATE OF BURIAL June 24, 1924

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88119

CERTIFICATE OF DEATH

101-001

D 88119

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 9 WARD)

2-FULL NAME John W. Kennemann

(a) RESIDENCE NO. 717 E 23rd St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?/ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. dt.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
(41)	41	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 24

(b) General nature of industry, business, or establishment in which employed (or employer) Telephone Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John Henry Kennemann

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ella Barfield

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hosp. Records
(Address)

15 JUN 24 1924 Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 1924

17

I HEREBY CERTIFY, That I attended deceased from 6-18, 1924, to 6.22, 1924, that I last saw him alive on 6-22, 1924, and that death occurred, on the date stated above, at 2:10 P m.

The CAUSE OF DEATH was as follows:

Chronic Nephritis -
Pericarditis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 6-20-24

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) ..... M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	6-25-24
20 UNDERTAKER	ADDRESS
George W. Farley	Fulton Ave

MARGIN RESERVED FOR BINDING

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Markum)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88120

D 88120

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME John Markum

(a) RESIDENCE NO. Fennert Hotel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE: Years 52; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10 NAME OF FATHER Frank Markum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Anna Fenton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Indiana

14 Informant (Address) Hospital Record

15 Filed , 19 Robert P. Harrison, Registrar

JUN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/24 19

17

I HEREBY CERTIFY, That I attended deceased from 5/10/24, 19, to 6/22/24, 19

that I last saw h alive on 6/22/24 19

and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension (Cardiac)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Talley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arnolton Indiana	6/26 1924
20 UNDERTAKER	ADDRESS
Emp U Talley	Fulton & Fayette

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8812F

D 8812F

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 N. Milton Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Stock.

(a) Residence No. 117 N. Milton Ave St., 6 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Minnie Stock.

6-DATE OF BIRTH (month, day and year) Jan. 31-1858

7-AGE, 66 yrs. 4 mos. 22 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coffee Roaster

(b) General nature of industry, business, or establishment in which employed (or employer) E. Ferry. Co.

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Germany.

PARENTS.

10-NAME OF FATHER, Balster Stock

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Ger.

12-MAIDEN NAME OF MOTHER, Sophie Wohlmacher

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Ger.

14- (Informant) Charles L. Stock.

(Address) 517 N. Bouldin St.

15- Filed ..... 192.....

Robert P. Harrison,

Registrar.

Burial Permit Clerk

JN2 4 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 22-1924

17- I HEREBY CERTIFY, That I attended deceased from 6/21st 1924 to 6/22nd 1924

that I last saw h.. alive on 6/22nd 1924

and that death occurred, on the date stated above, at 7.15 a. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart, cerebral hemorrhage

all due to Chronic Interstitial Nephritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic interstitial Nephritis

(Duration) uncertain yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) H. F. Tankin M. D

, 19 (Address) 119 N. Milton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL. June 25 1924

20-UNDERTAKER, Lilly & Zeile — ADDRESS 403 S. Wolfe St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88122

CERTIFICATE OF DEATH.

90 D 88122

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 617 S. Kenwood Ave. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Elizabeth Burke.

(a) Residence No. 617 S. Kenwood Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Burke.

6-DATE OF BIRTH (month, day and year) April 5-1856

7-AGE. 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at home.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto Co.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER. Christopher Zeidler

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Margaret Pittroff.

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Germany.

11- (Informant) Mrs. Sadie Weber (Daughter)

(Address) 617 S. Kenwood Ave.

13- Filed 1924 Robert P. Harrison, Registrar.

JUN 24 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 23-1924.

17- I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1924 to June 23, 1924, that I last saw h. alive on June 23, 1924 and that death occurred, on the date stated above, at 1.100. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart. (Sudden)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Kruger M. D

, 19 (Address) 2627 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cem. DATE OF BURIAL. June 25 1924

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 88123

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 900 N. Bradford ST., 7 WARD)

2-FULL NAME Veronica Fabai

(a) RESIDENCE NO. 900 N. Bradford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John C. Fabai

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: No occupation

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Czecho-Slovakia

PARENTS

10 NAME OF FATHER: Valentine Surlak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Czecho-Slovakia

12 MAIDEN NAME OF MOTHER: Hocaj

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Czecho-Slovakia

14 Informant: John Fabai
(Address): 900 N. Bradford St

15 JUN 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1923 to June 23, 1924
that I last saw her alive on June 23, 1924
and that death occurred, on the date stated above, at 11 o'clock A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Lucien B. Joska, M. D.

, 19 (Address) 845 E. Fairmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 26 1924
20 UNDERTAKER: Frank Evack Son	ADDRESS: 1906 Eastwood

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

88124

CERTIFICATE OF DEATH.

124 D 88124

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 S. Greene ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Jonkaitis

(a) RESIDENCE No. 212 S. Greene ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Chas. Shenkus

(Address) 212 S. Greene St.

15 Filed JUN 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1924, to June 23, 1924, that I last saw him alive on June 23, 1924, and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) X yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Brownbuss, M. D.

(Address) 615 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	6/26 1924
20 UNDERTAKER	ADDRESS
Chas B. Kuckauskas	637 S Paca

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88125

CERTIFICATE OF DEATH.

11 2 D 88125

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3549 Old Fredrick Road ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Regan

(a) RESIDENCE NO. 3549 Old Fredrick Road ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Regan

6 DATE OF BIRTH (month, day, and year) March 25 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Stubbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Regan
(Address) 3549 Old Fredrick Road

JUN 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, find that said deceased came to death
(autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) 15 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner)

June 23 1924 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 6/25/24 192

20 UNDERTAKER Martin Fahey Sons

ADDRESS 1827 N. Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88126
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

53

D 88126
Registered No.....

City of BALTIMORE: (No.) Municipal Tuberculosis Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Scott

(a) Residence No. 312 Colvin st. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1892

7-AGE. 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

070

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Sylvia Clay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). South Carolina

11- (Informant) Hospital Records

(Address) M.T.H.

JUN 25 1924 Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 21, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to June 21, 1924,

that I last saw her alive on June 21, 1924,

and that death occurred, on the date stated above, at 8.45 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray,

(Signed) L. A. Lally M. D

6-22-24 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel	6/25/24 19
20-UNDERTAKER,	ADDRESS
R. B. Brooks	1405 McElderry

Robert R. Kramer

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88127

CERTIFICATE OF DEATH.

D 88127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St Marys ST., 6 WARD)

2-FULL NAME Amelia Ford

(a) RESIDENCE No. 447 N Fulton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John T. Ford

6 DATE OF BIRTH (month, day, and year): April 23-1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Duchoeck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John T. Ford (Address) 447 N. Fulton Ave.

15 Filed JUN 25 1924, 19 ... ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1924, to June 23, 1924, that I last saw h alive on June 23, 1924, and that death occurred, on the date stated above, at 5 50 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis Pneumonia

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? 447 N Fulton

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Kahrs M. D.

June 25, 1924 (Address) 1301 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cemetery	June 26 1924
20 UNDERTAKER	ADDRESS
Thos C Christian Sons	1307 Jeffer

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88128

CERTIFICATE OF DEATH.

1824 D 88128

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Eastern & East Falls Aves. St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Moretti.

(a) RESIDENCE No. 1521 N. Chapel St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 20 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Nicholas Moretti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Johanna Conci.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14
Informant Joseph Moretti. (brother)
(Address) 406 S. High St.

15
Filed JUN 25 1924 192 ROBERT R. KRAUTER, Assistant,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probable accidental fall overboard.

(duration) ---- yrs. ---- mos ---- ds.

CONTRIBUTORY (Secondary)

(duration) ---- yrs. ---- mos. ---- ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

June 24, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ---- yrs., ---- mos., ---- ds. In the State ---- yrs., ---- mos., ---- ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemetery	6/25 1924
20 UNDERTAKER George J. Ruth	ADDRESS 175 Hanford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D 88129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7-18-001

D 88129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital 16 ST., WARD)

2-FULL NAME Rose Flintman

(a) RESIDENCE No. 1022 E. Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Flintman

6 DATE OF BIRTH (month, day, and year) about 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto St

15 JUN 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated umbilical Hernia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Hennessy, M. D.
(Coroner.)

June 24, 1924 (Address) 2807 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Henry Rus	June 25 1924
20 UNDERTAKER	ADDRESS
Last Rites	1424 E. Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Harry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88130

D 88130

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S Marine Hosp ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Hooter

(a) RESIDENCE NO. U. S. Marine Hosp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Entire yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. City of Wilmington

(c) Name of employer "

9 BIRTHPLACE (city or town) " (State or country)

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

J.C.Y.

14 Informant Hospital Records (Address) U.S.M.H. 70 Md

15 Filed JUN 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21 1924

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1924, to June 21, 1924, that I last saw him alive on June 21, 1924, and that death occurred, on the date stated above, at 3 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy - Bradular disease of heart. Chronic Parenchymatous Nephritis Arterial Sclerosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical test. Lab findings

(Signed) J C Graves, M. D.

6/6 1924 (Address) U. S Marine Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	6/25 1924
20 UNDERTAKER A. Grinnan & Bro	ADDRESS 1127 E Balto St

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

143 - 001

D 88131

CERTIFICATE OF DEATH.

D 88131

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Estella Colton

(a) RESIDENCE No 823 Edmondson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col-

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of Jno E. Colton
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9- 1903

7 AGE: Years 21 Months 5 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Isaac Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Evelina Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant: Jno. E. Colton
(Address) 823 Edmondson Ave

JUN 25 1924 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pelvic Peritonitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Abortion (accidental)

(duration) yrs. mos. ds.

(Signed) W. R. Gorman, M. D. (Coroner.)

June 25 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL June 25 1924

20 UNDERTAKER Edward Krusling ADDRESS 1210 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-23-21—E.B.K.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88132

CERTIFICATE OF DEATH.

5 D 88132

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1114 S. East Ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Weber

(a) Residence No. 1114 S. East Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, ~~or divorced~~ WIFE of (~~HUSBAND of~~) William Weber

6-DATE OF BIRTH (month, day and year) Aug. 15-1853

7-AGE.	If LESS than 1 day,
70 yrs. 10 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Henry Ulrich

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Muhl

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mrs. John Bauersfeld

(Address) 1114 S. East Ave

15- JUN 25 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 22-1924

17- I HEREBY CERTIFY, That I attended deceased from Jany 15th 1920 to June 22nd 1924

that I last saw her alive on June 21st 1924

and that death occurred, on the date stated above, at 6.55 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism
Osteo arthritis

(Duration) 4 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D.W. Gould M. D.

6/24/ 1924 (Address) 1011 N. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cemetery	June 25, 1924
20-UNDERTAKER.	ADDRESS
Zinkler + Zinkler	1739 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

88133 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88133

CERTIFICATE OF DEATH.

8 129

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. 2226 E. Biddle St., ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah M. Littleton

(a) Residence No. 2226 E. Biddle St., ...Ward...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin D.

6-DATE OF BIRTH (month, day and year) May 26, 1855

7-AGE. 69 yrs. mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, F. F. Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary A Jenkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Eda M. Ash

(Address) 2226 E. Biddle

15- Filed ... 192... ROBERT R. KRAUTER, Registrar.

JUN 25 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH. 1924

16-DATE OF DEATH (month, day and year) June 23,

17- I HEREBY CERTIFY, That I attended deceased from May 8, 1924, to June 23, 1924, that I last saw h[illegible] alive on June 23, 1924, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Test

(Signed) J. M. Dillett, M. D.

June 23, 1924 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	6/26, 1924
20-UNDERTAKER. Burkhardt Burkhardt	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88134

CERTIFICATE OF DEATH.

161-D 88134

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital, Balto., Md ST., 14 WARD)

2-FULL NAME Baby Schweizer

(a) RESIDENCE NO. Garrison Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Same yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22, 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or 5 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Mark Schweizer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER Hedwig Back

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Switzerland

14 Informant Hedwig Schweizer

(Address) Garrison Md

JUN 25 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1924, to June 22, 1924, that I last saw h alive on June 22, 1924, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity (4 months).

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination of fetus.

(Signed) E. W. Sickel, M. D.

, 19 (Address) Woman's Hospital, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Body reserved for scientific purposes.	19
20 UNDERTAKER	ADDRESS

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88135 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 33 Powell Ave (Rasp'eby) St., 27 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Goldschmidt

(a) Residence No. 33 Powell Ave St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if of foreign birth? 42 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: late Herman H. Goldschmidt

6-DATE OF BIRTH (month, day and year): Feb 1/58

7-AGE: 66 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS.

10-NAME OF FATHER: Kendel

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant) Mrs Aug. Borleis

(Address) 33 Powell ave

15-Filed JUN 25 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 23 24

17- I HEREBY CERTIFY, That I attended deceased from Feby 1924 to June 17. 24

that I last saw her alive on June 4 1924

and that death occurred, on the date stated above, at 2.50 p.m.

The CAUSE OF DEATH* was as follows:

Uterine Carcinoma

Under my Care 4 mos. ds.
(Duration)

CONTRIBUTORY (Secondary) Dysentery

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collenberg M. D

June 24 1924 (Address) 1810 E Baltimore St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore	6/26 1924
20-UNDERTAKER.	**ADDRESS**
Phil. J. Herwig	2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-21—M&T—100 Blks.

D 88136 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88136

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital STREET) (WARD) 25

REGISTERED NO. 188-23

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha L. Helmick.

(a) RESIDENCE No Hill Crest Ave & 4th St. Brooklyn WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April, 2, 1915.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginaa.

PARENTS

10 NAME OF FATHER Matthew Helmick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia.

12 MAIDEN NAME OF MOTHER Mary I Edwards.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Mary I. Helmick. (mother)
(Address) Hill Crest Ave & 4th St. Brooklyn

15 Filed JUN 25 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Given

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest. (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidentally struck and knocked do
by an automobile while crossing ro

(duration) yrs. mos

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

(Signed) Otto M. Reinhardt, M. (Coroner.)

June 24, 1924 (Address) 10 N. S. Charles St

*State the Disease Causing Death, or in deaths from Violent C state (1) Means and Nature of Injury, and (2) whether Ac Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tra Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mo

Where was disease contracted, if not at place of death?
Belle Grove Inn Road, C. C. Co.

June 22, 19

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DA

20 UNDERTAKER
John T. Berry

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88137

CERTIFICATE OF DEATH.

D 88137

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Clarkson ST. 23 WARD)

2-FULL NAME Margaret Gadd

(a) RESIDENCE NO. 1619 Clarkson ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel H Gadd

6 DATE OF BIRTH (month, day, and year) Feb 7 1849

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William F Gadd
(Address) 1619 Clarkson St

15 Filed JUN 25 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1924 to June 24, 1924
that I last saw he alive on June 23, 1924
and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Epheneabeae

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 26 1924
20 UNDERTAKER John F Denny	ADDRESS 915 Light St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88138

D 88138

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Bond ST., 7 WARD)

2-FULL NAME Melvina Jackson

(a) RESIDENCE NO. 616 N. Bond ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE — Years: 54 — Months: — — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs. M. Jackson
(Address) 616 N. Bond St.

15 Filed JUN 25 1924 19.. ROBERT R. PONTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1924, to June 23, 1924, that I last saw her alive on June 23, 1924, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH was as follows: Intestinal nephritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Gastro intestinal nephritis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Johnson M. D.

(Address) 1520 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 6/25 19 24

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Penna ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D 88139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Diggs

(a) RESIDENCE No 1519 N. Mount St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Diggs

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hod/carrier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Waterbury, Md

PARENTS

10 NAME OF FATHER Ananias Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Waterbury, Md

12 MAIDEN NAME OF MOTHER Elizabeth Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Waterbury, Md

14 Informant James S. Diggs (son)
(Address) Waterbury Md.

15 Filed JUN 25 1924 ROBERT R. KRAUTER Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/24 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Tetanus- accidently stepped on nail at his home June 10/24

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J S H Paeun (Coroner.), M. D.

6/23/24 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL John Wesley Bmre — DATE OF BURIAL 6/25/24

20 UNDERTAKER Daniel Easton — ADDRESS 916 Bmre

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88140

CERTIFICATE OF DEATH.

4 129

D 88140

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 W. Saratoga St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Gale

(a) Residence No. 107 W Saratoga St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. H. X Gale

6-DATE OF BIRTH (month, day and year): Jan 29 1857

7-AGE: 67 yrs. 4 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Edward Wright

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Ann Paine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14-
(Informant): H. Easter Gale
(Address): 107 W Saratoga St

15-
FILED JUN 25 1924 ROBERT R. KRAUTER, Special Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 27 1924

17- I HEREBY CERTIFY, That I attended deceased from April ....., 1924 to June 24 1924
that I last saw her alive on June 23 1924
and that death occurred, on the date stated above, at 1-P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis & Mitral Insufficiency
(Duration) ..... yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary): Don't Know
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No Medical

What test confirmed diagnosis?

(Signed) W K Speech M. D.

425- 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL: Fairmount — DATE OF BURIAL: June 27 1924

20-UNDERTAKER: Wm Cook — ADDRESS: 502 E. Lexington

Spec—12-23-21—E.B.K.S.—400 Blks.

Dr. Tovey ✓

D 88141 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-02 D 88141

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 1807 Barclay St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Virginina Stansbury

(a) Residence No. 1807 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced. (Write the word) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE Micajah Stansbury

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE About 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS

10-NAME OF FATHER Jesse M. Callison

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Penna

12-MAIDEN NAME OF MOTHER Julia Gordham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Md

14-Informant Mrs Geo C. Cook

(Address) Woodlawn Md

15-Filed JUN 25 1924 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 24 1924.

17- I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to June 24, 1924, that I last saw h. alive on June 24, 1924, and that death occurred, on the date stated above, at 11.50 a m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Old age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Reginald

(Signed) Reginald J. Tovey M. D

. 19 (Address) 4142 Northern

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Homestead Md	6/26, 19..
20-UNDERTAKER.	ADDRESS
William Cook	502 E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88142

D 88142

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Meister

(a) RESIDENCE NO. Bay View asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

JUN 25 1924

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 23 1924

17 I HEREBY CERTIFY, That I attended deceased from 6 - 17, 1924, to 6 - 23, 1924.

that I last saw h[illegible] alive on 6 - 23, 1924

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude A. Thomas, M. D.

6-25 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6-26 1924

20 UNDERTAKER Henry C. Cummings Sr.

ADDRESS 5171 Schroeder St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓

D 88143

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH D 88143

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Mina Johnson

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed JUN 25 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-1, 1924, to 6-23, 1924, that I last saw her alive on 6-22, 1924, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) Claude F. Brown M. D.

6-25 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 25 1924

20 UNDERTAKER [redacted]

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88144

CERTIFICATE OF DEATH.

6 57 D 88144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Jefferson ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Turner

(a) RESIDENCE NO. 1615 Jefferson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charlie W Turner

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm. Spriddle

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Edna Pembleton Daughter

(Address) 1615 Jefferson

15 Filed JUN 25 1924 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17

I HEREBY CERTIFY, That I attended deceased from June 4 1924 to June 23 1924.

that I last saw h alive on June 22 1924

and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene Foot left and Hand Rt

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetis Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) R J Young, M. D.

6/26, 1924 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jun 26 1924
20 UNDERTAKER	ADDRESS
Chas W. Johnson	446 N. Carolina St.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88145

CERTIFICATE OF DEATH.

D 88145

12 31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 805 N. Patterson Park Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry L. Voelker

(a) Residence No. 2810 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Angela Voelker

6-DATE OF BIRTH (month, day and year) Jan 20th 1892

7-AGE. 32 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Schaffer Co.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), City

PARENTS.

10-NAME OF FATHER, Ernest Voelker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), City

12-MAIDEN NAME OF MOTHER, Matilda Ballaberg

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Ernest Voelker

(Address) 2810 N. Patterson Park Ave

15- Filed JUN 25 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6/23/24

17- I HEREBY CERTIFY, That I attended deceased from April 11 1924 to June 23 1924

that I last saw him alive on June 23 1924

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Enteritis Phthisis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Phthisis Pulmonary

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? Bacillus in Sputum

What test confirmed diagnosis? Sputum

6/24/24 (Signed) Chas B Fenimore M. D

(Address) 718 N Patterson Park

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL. June 26 1924

20-UNDERTAKER, J. J. Moran — ADDRESS 300 E Baltimore

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Salvatore Maggio)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88146

CERTIFICATE OF DEATH.

D 88146

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home Infirmary ST., 5th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggio, Mr. Salvatore,

(a) RESIDENCE NO. 6823 S. Ponca WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mrs Jane Maggio

6 DATE OF BIRTH (month, day, and year) 1858 Stanchi

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	66	~~months~~ 3	~~days~~ 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 904

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Joseph Maggio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Bevellaca, —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Mr. Guiseppe Maggio 3009 W. Lanvale St.

15 Filed JUN 25 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 25 1924

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1924, to June 25, 1924, that I last saw him alive on June 25, 1924, and that death occurred, on the date stated above, at 4:00 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Clinical findings

(Signed) Cayetano Zanetta, M. D.

, 19 (Address) Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ New Cathedral DATE OF BURIAL JUN 27 19 24

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE.

MARGIN RESERVED FOR BINDING

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88147.

CERTIFICATE OF DEATH.

D 88147

118-8

16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST. Joseph Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Johnson

(a) RESIDENCE NO. 1119 N. Gilmor St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lee Custis
(Address) 1119 N.Gilmor St

Filed JUN 25 1924, 192 Robert P. Harrison Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis-gandrenous intestine

(Strangulated femoral hernia rt. side) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) E. E. Walker, M. D.
(Coroner.)

6/25/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 6/26/1924

20 UNDERTAKER Geo. F. A. Gibson — ADDRESS 1302 D.

GB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88148

CERTIFICATE OF DEATH.

83

1-PLACE OF DEATH

City of BALTIMORE (No. University Apts St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora Ward Hooper

(a) Residence No. University Apts St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Hooper

6-DATE OF BIRTH (month, day and year) Sept 1847

7-AGE. 76 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER George W Ginn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Frances Meredith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

11- (Informant) Mrs Mary Wingrave

(Address) University Apts

15- Filed JUN 25 1924 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 24 24

17- I HEREBY CERTIFY, That I attended deceased from ..... 19 17 to June 24 19 24

that I last saw h[illegible] alive on June 23 19 24

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) Some yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Softening

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. W. Steele M. D.

June 25 1924 (Address) 2431 Maryland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. June 26 1924

20-UNDERTAKER. John A. Mitchell — ADDRESS 2011 Fawn

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

36-002

D 88149

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., 23 Ward) Municipal Tuberculosis Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Rouzer

(a) Residence No. 1127 Sharpe st. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6-DATE OF BIRTH (month, day and year) 1916

7-AGE.			If LESS than 1 day.	
8 yrs.	mos.	ds.	hrs. or	mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Rouzer

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Hettie Sayles

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Maryland

14-(Informant)....Hospital Records.....

(Address).....M.T.H.....

15-

JUN 26 1924

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 24, 1924

17- I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1923 to June 24, 1924

that I last saw him alive on June 24, 1924

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous ostaitis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Lally, M. D

6-24- 1924 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn DATE OF BURIAL. June 27 1924

20-UNDERTAKER. John N. Toadvine ADDRESS 172 W. Fred St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88150

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1619 Bolton St., 14 Ward) Registered No. 73

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Doyle

(a) Residence No. 1619 Bolton St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. - mos. - ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel H. Doyle

6-DATE OF BIRTH (month, day and year) Sept. 4, 1861

7-AGE. 62 yrs. 9 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, -------- Flynn

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) William H. Doyle

(Address) 1619 Bolton St

JUN 26 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 25 1924

17- I HEREBY CERTIFY, That I attended deceased from August 1924, to June 25 1924, that I last saw h[e] alive on June 24 1924, and that death occurred, on the date stated above, at 5-02 m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(Duration) for 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(Duration) Few months yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward O'Meara M. D

June 25, 1924 (Address) 1 E. Read St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Cathedral Cemetery	June 27 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Bryer

172807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88151

CERTIFICATE OF DEATH.

90

D 88151

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Annie Breyer.

(a) RESIDENCE NO. 1303 James St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Frank Breyer

6 DATE OF BIRTH (month, day, and year) ——— 1856

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) + 037

(c) Name of employer +

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Angle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) John Hopkins Hospital

15 Filed JUN 2 6 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1924, to June 24, 1924, that I last saw h er alive on June 24, 1924, and that death occurred, on the date stated above, at 7 45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Autopsy M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bryer Bridge Md	6/27/24
20 UNDERTAKER	ADDRESS
J Rheuse & Co	221 N Broadway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88152

CERTIFICATE OF DEATH.

D 88152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 S Fremont St., 27 WARD)

2-FULL NAME William Heinlein

(a) RESIDENCE NO. 225 S Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rena Heinlein

6 DATE OF BIRTH (month, day, and year) Sept 18 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John H. Heinlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Fred Heinlein (Address) 225 S Fremont

15 Filed JUN 26 1924 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 23, 1924

that I last saw h alive on June 23, 1924

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) Independent yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

June 24, 1924 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	6-26 1924
20 UNDERTAKER	ADDRESS
Walter Schlosser	115 E Hoffman St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88153 ~~3291~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 88153

1-PLACE OF DEATH Johns Hopkins Hosp

CITY OF BALTIMORE: (No. ..... ST., 23 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Brennick

(a) RESIDENCE NO. 1117 Pennington ST., Ave. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): July 17, 1923

7 AGE — Years: — Months: 11 Days: 8 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Brennick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Elizabeth Ulbrecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Parents
(Address): 1117 Pennington Ave

15 JUN 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1924, to June 25, 1924, that I last saw her alive on June 25, 1924, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

1 Generalized miliary tuberculosis

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Tbc. meningitis

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. F. Weech, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: 6/26 1924

UNDERTAKER: William Fiackowski — ADDRESS: 1618 Eastern Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 88154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D 88154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 D. Luzerne Ave. St.; 1 WARD)

2-FULL NAME Adam Knach

(a) RESIDENCE. No. 716 D. Luzerne Av. St.; WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 24-24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	3 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Conr. Knach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Carrie Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Carrie Knach
(Address) 716 D. Luzerne av.

15 Filed JUN 26 1924 . 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 24 . 19 24, to June 24 . 19 24, that I last saw him alive on June 24 . 19 24 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia dystocia

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Swan M. D.

. 19 (Address) 26 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	June 26 1924
20 UNDERTAKER	ADDRESS
Stephen J. Kraikowski	1000 S. Kenwood

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gill

HEALTH DEPARTMENT—CITY OF BALTIMORE

88155 D

60-001 D 88155

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 18 WARD)

2-FULL NAME Mrs Carrie Gill

(a) RESIDENCE NO. 518 N. Fremont St ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. C. Gill

6 DATE OF BIRTH (month, day, and year): 04 14 1894

7 AGE — Years: 29 — Months: 6 — Days: ..... — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: G. J. Dustler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltic md

12 MAIDEN NAME OF MOTHER: Emily Gentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltic Md

14 Informant: George G. Gill
(Address) 518 N Fremont

15 JUN 26 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1924, to June 24, 1924, that I last saw h[illegible] alive on June 24, 1924, and that death occurred, on the date stated above, at 11 30 Am.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre, thyrotoxemia
Myocarditis, pericarditis
Cardiac hypertrophy.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & clinical findings

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: 6/26 1924

20 UNDERTAKER: Robert Brookeman — ADDRESS: Calhoun Hall

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88156

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88156

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH 1907 Bank St

City of BALTIMORE: (No. 1907 Bank St ..... St., 2nd ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fredaricka Christena Vogel

(a) Residence No. 1907 Bank ..... St., 2nd Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 43 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, ~~widowed, or divorced~~ (HUSBAND) of (or) WIFE of John Vogel

6-DATE OF BIRTH (month, day and year) May 5 1861

7-AGE, 63 yrs. 1 mos. 23 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Fredrick Doelterman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) John Vogel (Husband)

(Address) 1907 Bank St

15- FILED JUN 26 1924 GILBERT R. KRAUTER Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 24 1924

17- I HEREBY CERTIFY, That I attended deceased from June 20 1924 to June 24 1924

that I last saw her alive on June 24 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....

.....

.....

.....(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Unknown (Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Manual Examination

(Signed) C. L. Woodward, M. D.

June 24, 1924 (Address) 1540 N. Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Baltimore Cemetery	June 27, 1924
20-UNDERTAKER, Haner Bock & Son	ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JONES

Spec.–1-10-21–M&T–1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88157

D 88157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 17 WARD)

2-FULL NAME Emory Jones

(a) RESIDENCE NO. 508 Mann Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Nov 2, 1923

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
✓	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer: X

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Leroy Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Lou Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 26 1924, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24, 1924

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1924, to June 24, 1924,

that I last saw h... alive on June 24, 1924,

and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Generalized miliary tuberculosis

(duration) yrs. 1½ mos 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. N. Veech M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rec Cub Run Cem

DATE OF BURIAL: June 26 19 24

20 UNDERTAKER: Samuel R Grady

ADDRESS: Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 88158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 N Patterson Park ave St., 8 WARD)

2-FULL NAME Elizabeth Thompson

(a) RESIDENCE No. 1625 N. Patterson Park ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Widowed Robert Thompson

6 DATE OF BIRTH (month, day, and year) Feb 24 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	73	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Boulden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs Lloyd Ford

(Address) 1625 N. Patterson Park ave

15 JUN 6 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to June 24 1924.

that I last saw her alive on June 23, 1924,

and that death occurred, on the date stated above, at 11 50 A m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Ringwald, M. D.

June 25, 1924 (Address) 16 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 27 1924
20 UNDERTAKER	ADDRESS
Henry Lutz	N. Broadway 1203

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88159

REGISTERED NO. D 88159

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., W WARD)

2-FULL NAME Theador Parker-

(a) RESIDENCE NO 849 Chuse St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Sigle

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work born
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Bru Parker

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Pearl Johnson

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Pearl Catsema
(Address) 849 Chase st

15 Filed JUN 26 1924 192 ROBERT R. KRAUTER Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 25 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Justo Endustes

(duration) yrs 1/2 mos ds.

CONTRIBUTORY (Secondary) Arter sclerosis

(duration) yrs. mos. ds.

(Signed) W H Grinnalds, M. D.
(Coroner.)

6 25, 192 4 (Address) 1178 W Lanvale st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ct	June 26 1924
20 UNDERTAKER	ADDRESS
S. L. Brown's Son	1811 W Lanvale st

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88160 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88160

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Hilton ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Wich

(a) RESIDENCE NO. 604 Hilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. Wich

6 DATE OF BIRTH (month, day, and year) Nov. 23 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Wich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Müller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martha E. Wich

(Address) 604 Hilton St

15

JUN 26 1924 ROBERT R. KRAUTLE, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17

I HEREBY CERTIFY, That I attended deceased from June 21, 1924, to June 24, 1924,

that I last saw him alive on June 24, 1924,

and that death occurred, on the date stated above, at 12.50 Noon m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart

4 yrs (duration) 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical symptoms

(Signed) John Zierler + physician for fam. M. D.

19 (Address) 1113 Eutaw Place

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL June 27 1924

20 UNDERTAKER Mr. & Mrs. John H. Deufel & Son ADDRESS 801 W. Fayette

Cor.—1-12-23—M&T—100 Blks.

D 88161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 88161

1-PLACE OF DEATH Continental Building

CITY OF BALTIMORE: (No. Baltimore & Calvert Sts. ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph H. Wright.

(a) RESIDENCE No 1305 Madison Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a If married, widowed, or divorced, HUSBAND of Ruth Wright

6 DATE OF BIRTH (month, day, and year) March 18, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger.
(b) General nature of Industry, business, or establishment in which employed (or employer) Sheppard Stone renovating Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown, Md

PARENTS

10 NAME OF FATHER James H. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Ida Cooper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Ida Wright. (mother)
(Address) 1215 Harford Ave

15 Filed JUN 26 1924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull & both legs.
Accidental fall from a scaffold from the 17th. floor to 4th floor roof of Continental Buildings ds.

CONTRIBUTORY (Secondary) Out side of building. (duration) yrs. mos. ds.

(Signed) Otto M Reinhardt, M. D. (Coroner.)

June 25, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md DATE OF BURIAL 6/26 1924

20 UNDERTAKER George C Farley Sutton & Tayette ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88162 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 819 W Pine ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Thomas (Veney)

(a) RESIDENCE NO. 819 W. Pine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 7 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Veney

6 DATE OF BIRTH (month, day, and year) Jan 1, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Griffin Veney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Lucy Rich.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Coffey Thompson

(Address) 1512 E Monument St

15 JUN 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1924, to June 24, 1924,

that I last saw him alive on June 24, 1924,

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Cardiac)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Mitral Reg.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & X ray

(Signed) Walter [illegible] M. D.

6-24 1924 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL June 26 1924

20 UNDERTAKER Sam'l W. Chase ADDRESS 4 Woodbine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88163 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 88163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1721 E. Eager ST., 7 WARD)

2-FULL NAME Christina A. Matthews

(a) RESIDENCE No. 1721 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Jany 1/1904

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	20	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Conrad Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Christina A. Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Christina Matthews
(Address): 1721 E. Eager St.

15 Filed JUN 26 1924, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25/24

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) J. S. H. Patterson, (Coroner) M. D.

6/26/24, 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity — DATE OF BURIAL: 6/28/24, 192

20 UNDERTAKER: Penkler & Pinkler — ADDRESS: E. [illegible] 1739

Spec– 12-23-21—E.B.R.S.—400 Blks.

Dr Ruzicka
800 N Patterson Park

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88164
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 D 88164
Registered No.

City of BALTIMORE, (No. 4506 St George St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Mead

(a) Residence No. 4506 St George St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5-a-If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~ Emma C. Mead

6-DATE OF BIRTH (month, day and year) Jan 31 1859

7-AGE, 65 yrs. mos. ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.
10-NAME OF FATHER, B. F. Mead
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto Md
12-MAIDEN NAME OF MOTHER, Sarah Uggan
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-Informant, Emma C. Mead
(Address) 4506 St George St.

15-Filed JUN 26 1924 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH. 24

16-DATE OF DEATH (month, day and year). 6-25-24

17- I HEREBY CERTIFY, That I attended deceased from 6-1- 1924 to 6-25 1924 that I last saw h alive on 6-22 1924 and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH was as follows:
Mitral Regurgitation
acute Nephritis
Hypertension
(Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) F. Ruzicka M.D.
6 25 1924 (Address) 800 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery | DATE OF BURIAL. 6/27 1924

20-UNDERTAKER: Wm Cook | ADDRESS: 501 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88165 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D 88165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital 76 x 38 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Wolf

(a) Residence No. Joppa Road, Fullerton, Balto. Co. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 5 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 25 / 1886

7-AGE. 37 yrs. 10 mos. ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Unknown.
(b) General nature of industry, business, or establishment in which employed (or employer)..... 067
(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.
10-NAME OF FATHER, Chas. P. Wolf.
11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Unknown Md.
12-MAIDEN NAME OF MOTHER, Emma Sems.
13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant) Bay View Hospital
(Address) Eastern Ave.

15- Filed JUN 26 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/25/24

17- I HEREBY CERTIFY, That I attended deceased from June 19, 1924 to June 24, 1924 that I last saw him alive on June 24, 1924 and that death occurred, on the date stated above, at 12.30 A.M. The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane.

(Duration) ... yrs. ... mos. ... ds

CONTRIBUTORY (Secondary) Luetic Infection

(Duration) ... yrs. ... mos. ... ds

18-Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) H. Feldmann M. D.

, 19 (Address) Bay View Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn	June 27, 1924
20-UNDERTAKER.	ADDRESS
Wm Cook	522 E Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. ALICE ADAMS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88166 ✓ 161-001 D 88166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No..... ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Adams

(a) RESIDENCE NO. 226 N. Dallas St. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) April 4 1924

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Doris Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records. (Address) Johns Hopkins Hosp.

15 Filed JUN 26 1924 19.... ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to June 24, 1924, that I last saw her alive on June 24, 1924, and that death occurred, on the date stated above, at 10-40 8 m.

The CAUSE OF DEATH* was as follows:

Prematurity

Life

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. R. Ward, M. D.

(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodberry cemetery

DATE OF BURIAL 26 June 1924

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88167

CERTIFICATE OF DEATH.

10-1-90 ✓ D 88167

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 W. Biddle St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton N. White

(Residence in Baltimore: No. 434 W. Biddle St.; 50 yrs. mos. ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6-DATE OF BIRTH, Not known (Month) (Day), 186 (Year)

7-AGE, 63 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Messenger
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER (State or Country), Not known

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (State or Country), Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah E. White

(Address) 434 W. Biddle St.

JUN 26 1924

Filed ..... 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1924, to June 24 1924, that I saw h[illegible] alive on June 24 1924 and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 ds.

(Signed) J. B. Hughes M. D.

June 26 1924 (Address) 1413 E. Hill St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn | DATE OF BURIAL, June 27 1924

20-UNDERTAKER Jesse St. Fielden | ADDRESS 436 E. Biddle St

Spec—12-23-21—E.B.R.S.—400 Bks.

88168

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes' Hospital St., 25 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Fitch

(a) Residence No. Savage, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 14 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 4/25/1859

7-AGE. 65 yrs. 4 mos. 26 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm. Edward Whitehead

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Susie Berry

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs. Daisy Reedy

(Address) Savage, Md.

15-

Filed JUN 26 1924 ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6-26-1924.

17- I HEREBY CERTIFY, That I attended deceased from 6-13 1924 to 6-26 1924

that I last saw h[illegible] alive on 6-26 1924

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Ch. Cholecystitis &
Cholelithiasis
Empyema of Gall Bladder

(Duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/14/24

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) H. O. Harper M. D

, 19 (Address) Prague Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury** and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Savage Md

DATE OF BURIAL, June 29, 1924

20-UNDERTAKER, George E. French

ADDRESS Laurel Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

88169

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88169

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S. Arlington Ave ST., 18 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelina May Baines

(a) RESIDENCE NO. 122 S. Arlington Ave ST., 18 WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 28. 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady 067

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Bryer & Co.

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Francis Baines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Nelly F. Neary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Francis Baines
(Address) 122 S. Arlington Ave.

15 JUN 26 1924 ROBERT R. KRAUSE, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 4. 1924 to June 24 1924

that I last saw her alive on June 23. 1924

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Insufficiency of Mitral Valve

(duration) 1 yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) 1 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. J. Sobel M. D.

. 19 (Address) 1001 Virginia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL June 27 19

20 UNDERTAKER John J. Fields

ADDRESS 1200 W Fayette

Spec.—1-10-21—M&T—1500 Blks.

D 88170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D 88170

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 E. Cross ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Connors

(a) RESIDENCE NO. 236 E Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a ~~S~~married, ~~widowed or divorced~~

~~HUSBAND of~~ (or) WIFE of B.F. Connors

6 DATE OF BIRTH (month, day, and year) April 8 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Accomac Va

PARENTS

10 NAME OF FATHER Henry L Cockett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Va

12 MAIDEN NAME OF MOTHER Rachel Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Va

14 Informant Mrs Est Bailey (Sister)

(Address) 236 E Cross st

15 JUN 26 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1924, to June 25, 1924,

that I last saw her alive on June 24 1924

and that death occurred, on the date stated above, at 1-0 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Uterus.

(duration) 0 yrs. 9 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 7/1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry F Buettner, M. D.

, 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	JUNE 27 1924
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88171

REGISTERED NO. D 88171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp ST. No (FREDERICK L. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Fred L. Bearman

(a) RESIDENCE NO. 422 S. 15th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Bearman

6 DATE OF BIRTH (month, day, and year) Feb 13 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furnace Worker 047

(b) General nature of Industry, business, or establishment in which employed (or employer) Bethlehem Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Louis Bearman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Bearman

(Address) 422 S. 15th St

15 Date Received JUN 26 1924 ROBERT H. KRAUSER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-23 1924, to 6-25 1924.

that I last saw (was) alive on 6-25 1924,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure, (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) Jno A Tompkins, M. D.

, 19 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL June 28 1924

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88172

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... Municipal Tuberculosis Hospital St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Andrews

(a) Residence No. 505 S. Madeira st. St., ... Ward .....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Unknown yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not known

6-DATE OF BIRTH (month, day and year): 1864

7-AGE.	If LESS than 1 day,
60 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

140

9-BIRTHPLACE (city or town) ..... (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Joseph Andrews

11-BIRTHPLACE OF FATHER (city or town) ..... (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) ..... (State or Country), Poland

14- (Informant) Hospital Records H.T.H.

(Address) .....

15- Filed JUN 26 1924 19 ..... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 25, 1924

17- I HEREBY CERTIFY, That I attended deceased from May 13 19 24 to June 25 19 24, that I last saw him alive on June 25 19 24, and that death occurred, on the date stated above, at 1.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? X-ray, sputum

(Signed) L. A. Lally M. D

6-25-, 19 24 Address Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St. Stanislaus.	June 28" 19 24.
20-UNDERTAKER.	**ADDRESS**
M. J. Sadowski.	405 S. Ann St.

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

(a)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88173

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

18 2 D 88173

1-PLACE OF DEATH

City of BALTIMORE: (No. Curtis Bay St., 7 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Walter Radhuba

(Residence in Baltimore: No. 122 S. Caroll St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Feb (Month) 21 (Day) 1900 (Year)

7-AGE. 24 yrs. 4 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)... Lumber Co.

9-BIRTHPLACE, (State or Country), Balto Co

PARENTS.

10-NAME OF FATHER, Frank Radhuba

11-BIRTHPLACE OF FATHER, (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Mary Gelner

13-BIRTHPLACE OF MOTHER, (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Gelner

(Address) 122 S. Caroll

15- JUN 26 1924 Robert P. Harrison, 192.... Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 26 (Day) 192 4 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
fell from S.S. Roanoke
in Curtis Bay

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Kenlon M. D. (Coroner.)

June 26 1924 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St Stanislaus DATE OF BURIAL. June 27 1924

20-UNDERTAKER. F. W. Ozozuski ADDRESS 1930 Eastern Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88174

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 St. Paul St ST., 11 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Keidel

(a) RESIDENCE NO. 914 St. Paul St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline W. Knabe Keidel

6 DATE OF BIRTH (month, day, and year) June 2nd 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	86	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Manufacturer 886

(b) General nature of industry, business, or establishment in which employed (or employer) Piano Manufacturer

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Hanover, Germany

PARENTS

10 NAME OF FATHER Dr. George Keidel

11 BIRTHPLACE OF FATHER (city or town) Hanover (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotta Offel

13 BIRTHPLACE OF MOTHER (city or town) Hanover (State or country) Germany

14 Informant Mrs Edmund Lassiter (Address) 914 St Paul St

15 Filed JUN 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1924

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1924, to June 25, 1924, that I last saw him alive on June 25, 1924, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) None

(durstion) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None except Physical Exam.

(Signed) Wm A. Fisher, M. D.

. 19 (Address) 715 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem^	6-25 1924
20 UNDERTAKER Henry W. Jenkins Son Co	ADDRESS Orchard ne Cullodn

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 172644

D 88175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88175

Johns Hopkins Hospital

CERTIFICATE OF DEATH. X 31

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Melvin Hoagin

(a) RESIDENCE NO. Evansville Va ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. — mos. 11 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston Mass
(State or country)

PARENTS

10 NAME OF FATHER Fred Hoagin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C

12 MAIDEN NAME OF MOTHER Ruth Palmer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mass

14 Informant Records
(Address) Johns Hopkins Hospital

15 Filed JUN 26 1924, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1924, to June 24, 1924, that I last saw him alive on June 24, 1924, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ... yrs. 3 mos. (?) ds.

CONTRIBUTORY (Secondary) Miliary tuberculosis

(duration) ... yrs. ... mos. 11 ds. +

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? — X-ray

(Signed) H. H. Veech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evansville Va	6/27 1924
20 UNDERTAKER WM Cook	ADDRESS 502 E Mad

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88176

CERTIFICATE OF DEATH.

129 D 88176

1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 N. Stricker St., 16 Ward)

Registered No.....

2-FULL NAME Mrs. Mary Catherine Bounds

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1217 N. Stricker St., Ward. all of life

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Bounds.

6-DATE OF BIRTH (month, day and year) Mch 15/1862

7-AGE. 62 yrs. 3 mos. 10 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Catonsville Md.

PARENTS.

10-NAME OF FATHER. Geo. Schatz

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Betzel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant). Chas. M. Bounds

(Address). 1217 N. Stricker St

15- Filed ..... 19.. Robert P. Harrison, Registrar.

UN 26 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 25-24

17- I HEREBY CERTIFY, That I attended deceased from Sept 13 1923 to June 25 1924

that I last saw h.. alive on June 25 1924

and that death occurred, on the date stated above, at 12 10 p. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual methods

(Signed) George C. Shannon M. D.

June 26 1924 (address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. June 28. 1924

20-UNDERTAKER. Martin Fuhrer & Son

ADDRESS 827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 5 31 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Fred Milton.....

(a) Residence No..... 26 N. Spring..... St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colrd

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 14/1901

7-AGE. 23 yrs. 9 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 823

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Henry Milton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland.

14- (Informant)..... (Address) Hospital Records

15- Filed ..... 19 Robert P. Harrison, Registrar.

JUN 26 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 24, 24

17- I HEREBY CERTIFY, That I attended deceased from June 18, 1924, to June 24, 1924, that I last saw him alive on June 24, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendicitis - Ruptured - General peritonitis

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of June 19, 1924

Was there an autopsy? Yes

What test confirmed diagnosis? Surgical Pathological finding

(Signed) Wm. J. Faulton M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Arbury Lawn	6/27 1924
20-UNDERTAKER	ADDRESS
James E. Skinner	1625 E. Madison

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88178

CERTIFICATE OF DEATH.

31 D 88178

1-PLACE OF DEATH

City of BALTIMORE: (No. 2713 Parkwood Ave St., 13 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Leo Driscoll

(a) Residence No. 2713 Parkwood Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) June 31 1906

7-AGE. 18 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Student

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore City

PARENTS:

10-NAME OF FATHER. Frank Driscoll

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Anastalia Dougherty

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) Frank Driscoll

(Address) 2713 Parkwood Ave

15- FILED JUN 26 1924 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/24/24

17- I HEREBY CERTIFY, That I attended deceased from Mar. 1 1924 to June 24 1924

that I last saw him alive on June 24 1924

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? T.B. Found

(Signed) [illegible] M. D

6/24. 1924 (Address) 804 Courtenay Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem

DATE OF BURIAL. June 27 1924

20-UNDERTAKER. Martin Burke & Son

ADDRESS 1211 North

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88179

CERTIFICATE OF DEATH.

5 118-08

D 88179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Victor Bergeron.

(a) RESIDENCE No. 1045 N. Front St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or ~~divorced~~ HUSBAND of ~~WIFE~~ of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vegetable dealer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant G Schiaffino.

(Address) 220 N. Eutaw St.

15 Date JUN 26 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Junw 25, 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Shock after operation.

(duration) yrs. mos, ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

June 25, 1924 (Address) 1014 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

1045 N. Front St. June 23, 1924

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL June 28 1924

20 UNDERTAKER Wm Cook ADDRESS 501 E Eutaw

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—MAT—1500 Blks.

D 88180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88180

CERTIFICATE OF DEATH

1-PLACE OF DEATH Volunteers of American Hospital 418 W. Lexington St., Balto., Md.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2 S. 1st St., Brooklyn ST., 25 WARD)

2-FULL NAME Emma V. Custer

(a) RESIDENCE NO. 2 to 1st St., Brooklyn Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wh	Widowed.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas E. Custer -

6 DATE OF BIRTH (month, day, and year) April 20th 1873 51 years

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51-	2-	4-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Burkettsville Md.

PARENTS

10 NAME OF FATHER Alexander McDade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Irvin Custer - Son.
(Address) 2 S. 1st St., Brooklyn

15 Filed JUN 26 1924, 19 ..... Robert P. Harrisch, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24- 1924

17 I HEREBY CERTIFY, That I attended deceased from June-21, 1924, to June 24, 1924.

that I last saw h-- alive on June 23, 1924.

and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? died Volunteers Hosp 418 W Lexington

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Robert W Johnson M. D.

. 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Govans Presbyterian Cem Govans	June 27 1924
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88181

CERTIFICATE OF DEATH.

161-68

D 88181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3206 Elliott St. (or WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Gajewska

(a) RESIDENCE. No. 3206 Elliott St., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Marian Gajewski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Anna Gezynska

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Marian Gajewski
(Address) 3206 Elliott St

15 JUN 27 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1924, to June 26, 1924, that I last saw her alive on June 26, 1924, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature at 6 months

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brennahan, M. D.

6-27-1924 (Address) 3037 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	June 27 '24

20 UNDERTAKER F. W. Ozazewski ADDRESS 1730 Eastern Ave

Spec—12-23-21—E.H.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88182

CERTIFICATE OF DEATH.

90 D 88182

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 5333 Park Heights St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Carroll Busey Hoffman

(a) Residence No. 5333 Park Heights St., 27 Ward. Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 28 ds. How long in U. S., if of foreign birth? 69 yrs. 11 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Helen S. Hoffman

6-DATE OF BIRTH (month, day and year) June-27-1854

7-AGE. 69 yrs. 11 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Florist

(b) General nature of industry, business, or establishment in which employed (or employer). Flowers

(c) Name of employer. Self

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER. Ephraim Hoffman

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER. Caroline Goon

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14-(Informant) Mrs. Helen S. Hoffman

(Address) 5333 Park Heights Ave.

15- JUN 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 24-1924.

17- I HEREBY CERTIFY, That I attended deceased from June 23, 1924 to June 23, 1924

that I last saw him alive on June 23, 1924

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis -

(Duration) 3 yrs. 0 mos. 0 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) S A Dodds, M. D.

June 25 1924 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Hill Cemetery

DATE OF BURIAL. June 27, 1924

20-UNDERTAKER. STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Secretary)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall in plain terms, so that it may be properly classified. Exact statement of OCCUPATION instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88183

CERTIFICATE OF DEATH.

58-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2827 Guilford Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Hill Ehrhardt

(a) Residence No. 2827 Guilford Ave St., 12 Ward St Louis Mo.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 70 yrs. 6 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Theo. Ehrhardt

6-DATE OF BIRTH (month, day and year) Dec-21-1853

7-AGE, 70 yrs. 6 mos. 5 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), St Louis Mo.

PARENTS.

10-NAME OF FATHER, John M. Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Nottingham England

12-MAIDEN NAME OF MOTHER, Mary ? ? ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ? Nottingham England

14-

(Informant) Mrs Mary E Lohmeyer (daughter)

(Address) 2827 Guilford Ave

15-

JUN 27 1924

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 26-1924.

17- I HEREBY CERTIFY, That I attended deceased from May 10, 1924 to June 25, 1924, that I last saw h[illegible] alive on June 25, 1924, and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? St. Louis Mo.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood Exam.

(Signed) James C. Clark M. D.

June 26, 1924 (Address) LaTobe, Elwyn & Read Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 28 1924.

20-UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Secretary)

ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECO
should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
in plain terms, so that it may be properly classified. Exact statement of OCCU
instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88184

CERTIFICATE OF DEATH.

111-602

D 88184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Church Home & Inf. 18 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Szatai (Szatai)

(a) RESIDENCE NO. 431 N Caley ST., (Ward) City.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 ~~Single~~, Married, Widowed, ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosa Kun Szatai

6 DATE OF BIRTH (month, day, and year): 1880.

7 AGE: Years: 44 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Hungary.

PARENTS

10 NAME OF FATHER: Sandor Szatai

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Mari Kaka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Caroline Hunter (Address) 431 N Caley St.

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

JUN 2 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/25 1924

17 I HEREBY CERTIFY, That I attended deceased from June 3. 1924 to June 25 1924 that I last saw h... alive on June 25 1924 and that death occurred, on the date stated above, at 4 H 0 A m.

The CAUSE OF DEATH* was as follows:

Acute peritonitis.
Perforated
Duodenal ulcer

(duration) yrs. ● mos. 12 ds.

CONTRIBUTORY (Secondary): Acute Cardiac dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 6-3-24

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Cyetan Pauetter M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Park Cem.

DATE OF BURIAL: 6/27 1924

UNDERTAKER: Chas. E. Brandstrom

ADDRESS: 118 W. Mt. Royal Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88185

CERTIFICATE OF DEATH.

90 ✓ D 88185

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: 2627 Pratt & Scott ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Warfield

(Residence in Baltimore: No. 845 Hollins St.; 50 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept. (Month) 27 (Day), 1853 (Year)

7-AGE, 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Builder
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country), Carroll Co Md

PARENTS.

10-NAME OF FATHER, Chas E Warfield

11-BIRTHPLACE OF FATHER (State or Country), Howard Co Md

12-MAIDEN NAME OF MOTHER, Harriet R. Hold

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm M Warfield

(Address) 845 Hollins St

15- Filed JUN 27 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 25 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1924, to June 24 1924, that I saw him alive on June 24 1924, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Indefinite (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Dilitation (Cardiac)

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Harry Glassman M. D.

June 26, 1924 (Address) 2627 Western Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, 6/27, 1924

20-UNDERTAKER Robert Brookeden

ADDRESS 607 Calhoun Hollins

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-902 D 88186

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 Greenwillow St., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Hall

(a) RESIDENCE NO. 621 Greenwillow ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced (or) WIFE of Saul Cornish Hall

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 67

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wilmor Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Walter Cornish Hall

(Address) 519 Dolphin St.

15 JUN 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1924

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1924, to June 25, 1924, that I last saw h[illegible] alive on June 25, 1924, and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Lagrippe

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) ... yrs. ... mos. 21 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) James M. Hayes, M. D.

6/26 1924 (Address) 513 N Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL June 27 24

20 UNDERTAKER Samuel T. Newsley ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11

D 88187

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 S. 12th St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Ollinger (Ollinger)

(a) RESIDENCE NO. 401 S. 12th St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Minnie Ollinger

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary.

PARENTS

10 NAME OF FATHER John Ollinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary.

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Minnie Ollinger (Wife)
(Address) 401 S. 12th St

15 JUN 27 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25-24

17 I HEREBY CERTIFY, That I attended deceased from 6-17-24, 19, to 6-25-24, 19, that I last saw h alive on 6-25-24, 19, and that death occurred, on the date stated above, at 1 00 p m.

The CAUSE OF DEATH* was as follows:

Gangrene Emphysematous Appendicitis.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Generalperitonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of 6/17/24

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Jamison Jr. M. D.

, 19 (Address) 401 S 12th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Emmitsburg

DATE OF BURIAL 1924

20 UNDERTAKER Lilly & Quinn

ADDRESS 403 S. Wolfe St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88138

CERTIFICATE OF DEATH.

16 001 D 88188

1-PLACE OF DEATH

City of BALTIMORE: (No. 814 Woodyear St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby- Moody-

(a) Residence No. 914 Woodyear St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, Black.

5-Single,- Married, Widowed, or Divorced, (Write the word.) Baby-

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 6/25/24

7-AGE

0 yrs. 0 mos. 0 ds.

If LESS than 1 day, hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Walter Moody-

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country) Middlesex Va.

12-MAIDEN NAME OF MOTHER, Evelyn Waller-

13-BIRTHPLACE OF MOTHER (city or town) Middlesex
(State or Country), Va.

11-

(Informant).....

(Address).....

15-

JUN 27 1924

ROBERT R. KRAUTER,
Burial Permit Clerk
Registrar.

1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6-25-24

17- I HEREBY CERTIFY, That I attended deceased from 6-25- 19 24 to 6-25- 19 24

that I last saw h. alive on 6-25- 19 24

and that death occurred, on the date stated above, at 1:20 p m.

The CAUSE OF DEATH* was as follows:

prematurity

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Jansen M. D

6-25- 1924 (Address) 1702 Westwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ... 19...

20-UNDERTAKER.

ADDRESS

Commissioner Health.

JUN 26 1924

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1550

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D 88189

D 88189

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Coleman

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day, ... hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... Md.
(State or country)

PARENTS

10 NAME OF FATHER William Brown

11 BIRTHPLACE OF FATHER (city or town) ..... Va.
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Marion Coleman

13 BIRTHPLACE OF MOTHER (city or town) ..... Va
(State or country)

14 Informant ..... Johns Hopkins Hospital.
(Address)

15 Filed JUN 27 1924 ROBERT R. KRAUTER, Registrar
1554 Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1924

17 I HEREBY CERTIFY, That I attended deceased from June 23. 1924. to June 23. 1924.

that I last saw her alive on June 23. 1924.

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

6/23, 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUN 27 1924

20 UNDERTAKER: Commissioner Health.

ADDRESS

D 88190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 182 D 88190

1-PLACE OF DEATH (Registered No. C.....)

City of BALTIMORE: (No. formerly 4 East Fallsway St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. David Atwood

(Residence in Baltimore: No. Lombard & East Fallsway St.; yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: unknown (Month) (Day) 1 (Year)

7-AGE: 67 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lumberella
(b) General nature of Industry, business, or establishment in which employed (or employer): Mender

9-BIRTHPLACE, (State or Country): New York

PARENTS.

10-NAME OF FATHER: Atwood

11-BIRTHPLACE OF FATHER, (State or Country): unknown

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER, (State or Country): unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed JUN 27 1924, 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

PUBLIC HOSPITAL.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day) 1924 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Drowning
Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James H. Fenton M. D. (Coroner.)

June 25 1924 (Address) 705 E. Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: PUBLIC CEMETERY. DATE OF BURIAL: JUN 26 1924, 19..

20-UNDERTAKER. ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 88191 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 W Dolphin ST.; 17 WARD) REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dalia Merritt

(a) RESIDENCE. No. 509 Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 24 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
35	~~1889~~	~~March~~ 3	~~24~~ 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Days work

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gabriel Merritt

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Regina Merritt Sister
(Address) 256 W Dolphin

15 JUN 27 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1924

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1924, to June 26, 1924, that I last saw her alive on June 25, 1924, and that death occurred, on the date stated above, at 7 45 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Indigestion and Exema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) Samuel A. Bain, M. D.

(Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	6/29 1924
UNDERTAKER	ADDRESS
Geo. T. A. Gebau	1705 Druid Hill Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT---CITY OF BALTIMORE

D 38192

CERTIFICATE OF DEATH

D 38192

1 PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 307 Presstman ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian Lewis

(Residence in Baltimore: No. 307 Presstman In Balto, Md. 0 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Female	Col	Married

6-DATE OF BIRTH: June (Month) 24 (Day), 1924 (Year)

7-AGE: 41 yrs. 1 mos. 25 ds. If LESS than 1 day, ... hrs., or ..... min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE (State or country): Baltimore Md

PARENTS

10-NAME OF FATHER: Louis Carroll

11-BIRTHPLACE OF FATHER (State or country): Frederick Co. Md.

12-MAIDEN NAME OF MOTHER: Lola Norton

13-BIRTHPLACE OF MOTHER (State or country): Harford Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sara Ethel Lewis

(Address) 5831 Philadelphia Pa

15-

JUN 27 1924

ROBERT R. KRAUTER, REGISTRAR
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: June (Month) 26 (Day), 1924 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 23, 1924, to June 26 1924, that I saw her alive on June 26, 1924, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tuberculosis,

from history (Duration) about 6 months, yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Ascites, Nephritis ?

Cardiac Dg. (Duration) ..... yrs ..... mos ..... ds.

(Signed), C Hamm M. D.

June 26, 1924 [Address] 1245 Hanover St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn — DATE OF BURIAL: 6/28/24, 191.....

UNDERTAKER: P. L. Groh — ADDRESS: 405 McElderry

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88193 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 D 88193

CERTIFICATE OF DEATH. 6

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Jefferson ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Anthony

(a) RESIDENCE NO. 1527 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: general domestic

(b) General nature of industry, business, or establishment in which employed (or employer): general

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Margaret Wagner

(Address) 5-29 Eutaw

15 Filed JUN 27 1924 ROBERT B. KRAUTH, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1924

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1924, to June 24, 1924, that I last saw her alive on June 24, 1924, and that death occurred, on the date stated above, at 12:20 p.m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Infirmities of age

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Signed Jno. C. Robinson, M.D.

(Address) 1526 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: June 27 1924

20 UNDERTAKER: Mrs. P. C. Elliott — ADDRESS: 1745 Auburn

Spec.—1-10-21 M&T 1500 Blks.

D 88194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88194

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2012 N. Fayette ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose M. Rogan

(a) RESIDENCE NO. 2012 N Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) (Home)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Thomas M. Rogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. McConville

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas M. Rogan (Address) 2012 N Fayette

15 Filed JUN 7 1924 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 1924

17 I HEREBY CERTIFY, That I attended deceased from June 15 1924 to June 25 1924,

that I last saw h[illegible] alive on June 24 1924,

and that death occurred, on the date stated above, at 9.50 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

about 3 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Findings

(Signed) Leonard McCosker, M. D.

June, 1924 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem	6/26 1924
20 UNDERTAKER	ADDRESS
J. Slaughter & Son	131 E Lexington

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88195

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88195

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1241 E Monument ST., 1 WARD) 75

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Young

(a) RESIDENCE No. 1241 E Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Young

6 DATE OF BIRTH (month, day, and year) Nov. 8th 1847

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	76	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Va

PARENTS

10 NAME OF FATHER Frederick Heyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Pauline Fahey

(Address) 1241 E Monument St

15 Filed Robert P. Harrison, Registrar

UN2 7 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/24 19

17

I HEREBY CERTIFY, That I attended deceased from 12/1/23, 19..., to 6/26/24, 19...,

that I last saw her alive on 6/26/24, 19...,

and that death occurred, on the date stated above, at 3.10 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (duration) Years

Cerebral Hemorrhage

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert R. Levi, M. D.

6/27/24 (Address) 1201 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 30th 1924
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

Cor.—1-12-21—M&T—100 Blks.

D 88196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88196

CERTIFICATE OF DEATH.

74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5017 Elmer Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine V. Weldon

(a) RESIDENCE NO. 5017 Elmer Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Weldon

6 DATE OF BIRTH (month, day, and year) Dec 29 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) E. Md

14 Informant Mrs E. Ford (Address) 5017 Elmer Ave

15 Filed JUN 2 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by Pneumonia (cause) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo. Morrison M. D. (Coroner.)

June 26, 1924 (Address) 3692 Rolandon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 28 1924
UNDERTAKER John O. Mitchell	ADDRESS 1201 W Fayette

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88197

CERTIFICATE OF DEATH.

D 88197

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Margaret Wetzel

(a) RESIDENCE No. White Sulphur ST., WARD White Sulphur Springs W. Va

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 2 (ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER David Wetzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Cassie O'Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Friends.
(Address) Johns Hopkins Hospital

15 JUN 27 1924 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1924, to June 27, 1924, that I last saw h e alive on June 27, 1924, and that death occurred, on the date stated above, at 9 45 a.m.

The CAUSE OF DEATH* was as follows:

Brain tumor left frontal region & abscess.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonitis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of June 17

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) J. H. Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL White Sulphur W. Va

DATE OF BURIAL 6/29/1924

UNDERTAKER Spiggs

ADDRESS Chas. F. Evans & Son 1180 W. Baltimore St.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-21-21—E.B.B.S.—400 Pks.

SADIE DUCKETT

D 88198 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88198

CERTIFICATE OF DEATH.

4 38

1-PLACE OF DEATH Bay View Hospital. Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Duckett

(a) Residence No. 733 W. Mulberry (mulberry) St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Blk.	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Duckett

6-DATE OF BIRTH (month, day and year) 1887

7-AGE	If LESS than 1 day,
37 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown.

11-BIRTHPLACE OF FATHER (city or town).....Do.
(State or Country), Do.

12-MAIDEN NAME OF MOTHER, Do.

13-BIRTHPLACE OF MOTHER (city or town).....Do.
(State or Country). Do.

11- (Informant) Bay View Hospital
(Address) Eastern Ave., extended.

15- Robert P. Harrison, Registrar.
JUN 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/26/24.

17- I HEREBY CERTIFY, That I attended deceased from June 5, 1924 to June 25, 1924

that I last saw her alive on June 25, 1924

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septic Infection

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and para...

(Signed) N. G. Maguire M. D.

. 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
Mt. Auburn Cem	6/28/24
20-UNDERTAKER.	ADDRESS
Daniel Easton	916 Bond

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88199

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 9 N. Smith St., 18 Ward) Registered No. 74-001

2-FULL NAME Henry Eby

(a) Residence No. 9 N. Smith St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Fem

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) January 17 1875

7-AGE, 49 yrs. — mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Henry Eby

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Maria Deakle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Rev. Eby

(Address) 9 N. Smith St.

15- Filed JUN 27 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/26/24

17- I HEREBY CERTIFY, That I attended deceased from June 24, 1924 to June 26 1924

that I last saw him alive on June 26 1924

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Frank E. Wagner M. D.

(Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem.	6/28/24
20-UNDERTAKER.	ADDRESS
Dan'l Easter	Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—B.B.R.S.—400 Blks.

D 88200

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88200

43

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1826 Harlem Avenue St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....William W. Wilbourn.....

(a) Residence No. 1826 Harlem Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Maude L. Wilbourn

6-DATE OF BIRTH (month, day and year) Jan. 17, 1861

7-AGE.	If LESS than 1 day,
63 yrs. 5 mos. 9 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Salesman

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Washington (State or Country), D. C.

PARENTS.

10-NAME OF FATHER, Lewis P. Wilbourn

11-BIRTHPLACE OF FATHER (city or town) Portsmouth, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Alice C. Wall

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Baltimore Maryland

14- (Informant) Mrs. Maude L. Wilbourn

(Address) 1826 Harlem Ave.

15- Filed Robert P. Harrison, Registrar.

JUN 27 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 26, 1924

17- I HEREBY CERTIFY, That I attended deceased from March 15, 1924 to June 26, 1924

that I last saw h[illegible] alive on June 26, 1924

and that death occurred, on the date stated above, at 9.15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. L. Long, M. D.

6-27, 1924 (Address) 418 Southway, Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 1924
London Park Cem	June 30
20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 N. Balto St

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 8820[illegible] HEALTH DEPARTMENT—CITY OF BALTIMORE D 8820[illegible]

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital, 16 Ward)

Registered No. 41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Abraham

(a) Residence No. 828½ Calverton Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta B. Abraham

6-DATE OF BIRTH (month, day and year) Jan. 30, 1882

7-AGE.	If LESS than 1 day.
42 yrs. 4 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Florist for

(b) General nature of industry, business, or establishment in which employed (or employer): Hilbert

(c) Name of employer: Company.

9-BIRTHPLACE (city or town): Baltimore (State or Country): Maryland

PARENTS.

10-NAME OF FATHER, Alban Abraham

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Lucy Hill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

14- (Informant) Mrs. Augusta B. Abraham

(Address) 828½ Calverton Road

15- 16- Robert P. Harrison, Registrar.

BN2 71924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 27, 1924

17- I HEREBY CERTIFY, That I attended deceased from June 7, 1924, to June 27, 1924, that I last saw him alive on June 27, 1924 and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cellulitis with general Septicemia (of lower left leg)

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? (Baltimore)

Did an operation precede death? yes Date of June 11, 1924

Was there an autopsy? no

What test confirmed diagnosis? Laboratory + clinical

(Signed) Joseph B. Cook M. D.

6-27-1924 (Address) 1123 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19
Loudon Park (Bur)	
20-UNDERTAKER. Joseph B Cook	ADDRESS 1003 N Fulton Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88202

17283 88202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Georgeanus

(a) RESIDENCE NO. 412 Market St ST., WARD Harrisburg Pa,

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	3	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Prop Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Augustin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Katherine Nicanda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Records

(Address)

JUN 27 1924 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to June 27, 1924

that I last saw h alive on June 27, 1924

and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephrectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/27/24

Was there an autopsy? Yes What Cause of Death was not explained

What test confirmed diagnosis?

(Signed) Winfield W Scott, M. D.

, 19 24 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg Pa	Jun 27 1924
20 UNDERTAKER	ADDRESS
Joseph Cabers	221 Berry

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

1219 Poplar Grove
Dr Friedenwald

D 88203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88203

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1301 Longwood St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Rosen

(a) Residence No. 1301 Longwood St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Maxey Rosen

6-DATE OF BIRTH (month, day and year): July 27-1845

7-AGE: 79 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): ---

(c) Name of employer: ---

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER: Jesse Browne

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14-

(Informant): Jesse Hayes

(Address): 1301 Longwood St.

15-

Filed JUN 28 1924

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 26-1924

17- I HEREBY CERTIFY, That I attended deceased from June 16, 1924, to June 26, 1924, that I last saw her alive on June 26, 1924, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis & Oedema of Lungs (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) John F. Friedenwald M. D.

6/27, 1924 (Address) 1219 Poplar Grove St.

State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 6/28, 1924

20-UNDERTAKER: Weidman Co.

ADDRESS: 502 E. North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88204

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88204

CERTIFICATE OF DEATH.

1-PLACE OF DEATH House of Good Shepherd Co. Hosp

CITY OF BALTIMORE: (No. [illegible] Mount and Hoffman Sts ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary J Lechenstein

(a) RESIDENCE NO. House of Good Shepherd Convent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 2

6 DATE OF BIRTH (month, day, and year) July 22, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Cumberland Maryland

PARENTS

10 NAME OF FATHER 2

11 BIRTHPLACE OF FATHER (city or town) 2 (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) 2 (State or country) Tankstown

14 Informant John J. Bakey Jr (Address) 1318 Light St

15 Filed JUN 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1924

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1924, to June 27, 1924.

that I last saw h[illegible] alive on June 25, 1924

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma fundus uteri

(duration) 4 yrs. 3 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos Brady, M. D.

, 19 (Address) 1107 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery.	6/28/ 1924
20 UNDERTAKER	ADDRESS
Jno J Bakey & Sons.	1318 Light St.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hosp 25 141 Registered No.....

City of BALTIMORE: (No.....St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Wivell

(a) Residence No. Emmitsburg Md St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Wivell

6-DATE OF BIRTH (month, day and year) Aug 18 1872

7-AGE. 51 yrs. 11 mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Emmitsburg Md.

PARENTS.

10-NAME OF FATHER, Henry Singo

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New Oxford Pa

12-MAIDEN NAME OF MOTHER, Virginia Rider

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Emmitsburg Md

14- (Informant) Mrs Frank Kain

(Address) 402 E Ridgewood ave

15- Filed June 28 1924 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 27 1924

17- I HEREBY CERTIFY, That I attended deceased from 6/16/24 19..., to 6/27/24 19...,

that I last saw her alive on 6/27/24 19...,

and that death occurred, on the date stated above, at 10.20P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

20 minutes
(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Myomata Uteri

Operation (Duration) ...yrs...mos...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/19/24.

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H.W. Harper M. D

, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Emmitsburg Md.	June 29, 1924
20-UNDERTAKER.	ADDRESS
Chas. L. Black	742 W. North ave.

JUN 28 1924 Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88206

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88206

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; No. St. Joseph's Hosp. ST., 9 WARD)

2-FULL NAME Margaret Wilke

(a) RESIDENCE NO. St Joseph's Hosp. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Wilke

6 DATE OF BIRTH (month, day, and year) 6/5/1865

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	60	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant St Joseph Hospital (Address) Eutaw & Oliver Sts.

15 Filed ....., 19 Robert P. Harrison, Registrar

JUN 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25 1924

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1924, to June 25, 1924, that I last saw her alive on June 25, 1924, and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heat Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? St. J. H.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Lybert, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	6/28/24
20 UNDERTAKER George J Rutt	ADDRESS 1135 Hanford

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88207

1-PLACE OF DEATH

City of BALTIMORE: (No. 1520 E. Pratt St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph. Majchrzak

(a) Residence No. 1520 E. Pratt St., Ward.....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 23 1924

7-AGE.	If LESS than 1 day,
....yrs. 2 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Felix . Majchrzak

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Leokadya. Niewiadomski

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country),

11- (Informant) Mr. Felix. Majchrzak

(Address) 1520 E. Pratt Street

15- JUN 2 81924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 27/24

17- I HEREBY CERTIFY, That I attended deceased from June 16 1924 to June 27 1924

that I last saw h[illegible] alive on June 26 1924

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Toxic Encephalitis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acidosis

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam Lab.

(Signed) A. Flexner, M. D.

June 27. 1924 (Address) 24 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 28 1924

20-UNDERTAKER,	ADDRESS
John A. Weber	1803 Bank St

CAUTION—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88208

CERTIFICATE OF DEATH.

24001 ✓ D 88208

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 Maryland Ave ST., 17 WARD)

2-FULL NAME William H. Shanck

(a) RESIDENCE NO. 2742 Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia A Shanck

6 DATE OF BIRTH (month, day, and year) Mr 15 53

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 230

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John H Shanck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Georgia Shanck (Address) 2742 Md ave

15 Filed JUN 28 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1924

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1924, to June 26, 1924, that I last saw him alive on June 25, 1924, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

6

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Gustav H Wolcenske, M. D.

June 27, 1924 (Address) 1120 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL June 28 1924

20 UNDERTAKER W M Routson — ADDRESS 2238 N Mt

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-21—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88209

D 88209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 E. Barney St. ST., 24 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles A. Johnson.

(a) RESIDENCE No 114 E. Barney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 59 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or ~~divorced~~ HUSBAND of ~~XXXXX~~ Annie E. Johnson.

6 DATE OF BIRTH (month, day, and year) October 12, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R. Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charles A. Johnson. Jr. (son)
(Address) 114 E. Barney St.

15 Filed JUN 28 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.

June 25, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. | DATE OF BURIAL 6/28/1924

20 UNDERTAKER E. & B. Harle | ADDRESS 115 E. [illegible]

Spec—12-23-21—E.D.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88210

D 88210

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Caroline Johnson

(a) Residence No... Preston Valley Ave St., ... Ward.....
(Usual place of abode) (If non-residents give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE, about 63 yrs. ..... mos. ..... ds. Unknown

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)..... 087

(c) Name of employer.....

9-BIRTHPLACE (city or town)..Balto Co.,
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm Johnson

11-BIRTHPLACE OF FATHER (city or town)..... —
(State or Country),

12-MAIDEN NAME OF MOTHER, Eliza Parker

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country),

14-

(Informant)... Jane Kervanee

(Address)..... 1204 Dark Hill ave

15-

Filed..... Robert P. Harrison, Registrar.

JUN 6 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 25/24

17- I HEREBY CERTIFY, That I attended deceased from No record ....., 19....., to....., 19.....,

that I last saw h.. alive on..... June 22 ....., 19 24

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteno sclerosis

3 Dys (Duration)..yrs..mos..ds.

CONTRIBUTORY (Secondary) General apoplexy

(Duration)..yrs..mos..ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

June 25, 1924 (Signed) F A Warner, M. D. (Address) 1132 Valley st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mount auburn — DATE OF BURIAL, Jun 28... 1924

20-UNDERTAKER, John H Owens — ADDRESS 538 Dolphin

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 88211

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 66 D 88211

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Jail. ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lester Thomas.

(a) RESIDENCE No 519 N. 12th. St. Richmond Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.--- mos. 21 ds. How long in U. S., If of foreign birth? ---yrs.--- ---mos.--- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	-----	-----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pencil Peddler.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER John Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Bettie Turner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant James Wood. (nephew)
(Address) 519 N. 12th. St. Richmond Va.

15 Filed JUN 28 1924, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.
Wood alcohol.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June 27, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cemtery Richmond Va.	June 28 1924
20 UNDERTAKER	ADDRESS
Mrs Christian Miller	2334 Jefferson St

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88212

D 88212

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phillip S. Wall

(a) RESIDENCE NO. 1802 W North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	~~married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Fanny McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Cornelius Wall (Address) 1540 N. Stricker

15 Filed ....., 19.... Robert P. Harrison, Registrar

Daniel Permit Clerk

IN 2 8 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

I HEREBY CERTIFY, That I attended deceased from June 23, 1924, to June 27, 1924, that I last saw h[illegible] alive on June 27, 1924, and that death occurred, on the date stated above, at 6 05 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Clin. data

(Signed) L. K. Fargo, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL June 30 19 24

20 UNDERTAKER Wm J Tickner & Sons ADDRESS N. & Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21 - E.R.R.S. - 400 Bks.

White 1151 E-22nd

D 88213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88213

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1160 East North St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kernan

(a) Residence No. 1160 East North St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) (Unknown)

7-AGE: About 82 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ax Grinder

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Richard Kernan

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Bessie McCall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-

(Informant): Nellie Kernan

(Address): 1156 E. North Ave

15-

This 28 day of JUN 1924 1924 Robert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6/26/24

17- I HEREBY CERTIFY, That I attended deceased from April 27 1924 to June 26 1924 that I last saw h.. alive on June 26 1924 and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Laryngeal Carcinoma

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Thomas H. Slicer M.D.

, 19 (Address) 45 E. 22nd St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Harford Rd

DATE OF BURIAL: 6/30 1924

20-UNDERTAKER: William Cook

ADDRESS: 502 E. North Ave

Burial Permit Clerk

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88214

M-4-901 D 88214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1236 Ridgley St. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Nazarenus

(a) RESIDENCE. NO. 1236 Ridgly ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Nazarenus

6 DATE OF BIRTH (month, day, and year) Sept 6. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Ottman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert Nazarenus (Address) 1236 Ridgely St

15 Filed N 2 8 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1924

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1924, to June 26th, 24. that I last saw h.. alive on June 25th, 24. and that death occurred, on the date stated above, at 9.00 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Incidental Nephritis

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Poulton M. D.

6-27, 1924 (Address) 3909 Seamon Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 28 1924

20 UNDERTAKER W. M. Cook ADDRESS 502 E. Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

REVISED FOR 1919

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 38215

D 38215

CERTIFICATE OF DEATH.

REGISTERED NO. 4

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 Chapel ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Belle

(a) RESIDENCE NO. 929 Chapel ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Belle

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimo. (State or country)

PARENTS

10 NAME OF FATHER John Medly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co Md

12 MAIDEN NAME OF MOTHER Susan Linzel

13 BIRTHPLACE OF MOTHER (city or town) P. George (State or country) County Md

14 Informant Alexander Belle

(Address) 924 N. Wanda

15 JUN 28 1924 Robert P. Harrison, ... 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25 1924

17 I HEREBY CERTIFY, That I attended deceased from 6-22 .19 24 to 6-24 .19 24

that I last saw her alive on 6-24 .19 24

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptom-complex

(Signed) L. A. Walters M. D.

. 19 (Address) 1311 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cemetery	June 25 19 24
20 UNDERTAKER	ADDRESS
Wm. R. Collett	Baltimore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 112. D 88216

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 N. Mulby ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl L. McCoy

(a) RESIDENCE NO 903 N Mulberry st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb-16-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phoenix Md Balto Co

PARENTS

10 NAME OF FATHER Chas McCoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba

12 MAIDEN NAME OF MOTHER Hattie Amstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucile Byrd
(Address) 913 N Mulberry St

15 Filed ..... 192 Robert P. Harrison, M.D. Registrar

JUN 28 1924 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27— 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Tuberculosis

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Heart & Food

(duration) yrs. mos. 3 ds.

(Signed) W. H. Forsyth, M. D.
(Coroner.)

6-28, 1924 (Address) 1127 N. Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 6/28 1924

20 UNDERTAKER John H. Toadvine — ADDRESS 142 Lexington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 88217

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 127

CITY OF BALTIMORE: (No. Union Memorial Hospital St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. Watts.

(a) RESIDENCE NO. Cambridge apts., Baltimore. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	White.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) June 17, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country) N. Y.

PARENTS

10 NAME OF FATHER Thomas S. Watts

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Annie Lory.

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) N.Y.

14 Informant Hospital Record

(Address) ~~Robert P. Harrison,~~

15 JUN 28 1924 19 Burial Permit Clerk. Registrar

via Penn. R.R. Escort - T. C. Freidorn

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1924

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to June 28, 1924.

that I last saw him alive on June 28, 1924

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis, Hemorrhagic.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 24, 1924

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) A.B. Price, M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem. New York City	June 28 1924
20 UNDERTAKER A. N. Meaver & Son	ADDRESS 846 N. Calvert

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hosp

City of BALTIMORE: (No. Mary Catherine Cascio St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-~~FULL NAME~~ 512 Harlem Ave

(a) Residence No..... St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. W

5-Single, Married, Widowed, or Divorced, (Write the word.) —

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 5 minutes yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of Industry, business, or establishment in which employed (or employer). pd

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Philip P Cascio

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Mary R. O'Brien

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto

11- (Informant) Philip C Cascio

(Address) 512 Harlem Ave

15- Filed ..... 19?

Robert P. Harrison, Registrar.

JUN 28 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/27/24

17- I HEREBY CERTIFY, That I attended deceased from 6/27/24 19..., to 6/27/24 19...

that I last saw her alive on 6/27/24 19...

and that death occurred, on the date stated above, at 3.35P m.

The CAUSE OF DEATH* was as follows:

Intra-cranial Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Forceps delivery Prolonged labor of mother

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H O Harper M. D

, 19 (Address) St Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	June 19 24
20-UNDERTAKER. John L Fields	ADDRESS 1200 W Fayette

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

1918 Lemmon St

D 88219

HEALTH DEPARTMENT—CITY OF BALTIMORE) 88219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St., No. Ward) 131

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Heatwole

(a) Residence No. 1918 ~~Lombard~~ Lemmon St. City Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? —— yrs. —— mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F. Female

4-COLOR OR RACE W. White

5-(Single, Married, Widowed, or Divorced (write word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 30-1872

7-AGE 54 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Do not know

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Do not know

12-MAIDEN NAME OF MOTHER, Do not know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Do not know

14- (Informant) Mrs. Lena Mcdaf

(Address) 1918 Lombard St City

15- Filed JUN 28 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-27-24

17- I HEREBY CERTIFY, That I attended deceased from 5-7- 1924, to 6-27 1924

that I last saw h[illegible] alive on 6-27 1924

and that death occurred, on the date stated above, at 2 55? p.m.

The CAUSE OF DEATH* was as follows:

Acute Cystitis-Pyelitis

Pyonephritis

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of 5/17/24

Was there an autopsy? Phys. Dgs — Lab Work

What test confirmed diagnosis? Cystoscopy

(Signed) H W Harper M. D

, 19 (Address) St. Agnes Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Westlawn

DATE OF BURIAL June 30 1924

20-UNDERTAKER, F B Hippert

ADDRESS 2236 Frederick

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Blks.

D 88220

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88220

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 325 Wellington St., 20 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C. Dunham

(a) Residence No. 325 Wellington Lane St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5-If married, widowed or divorced HUSBAND of (or WIFE of) Margaret A. Dunham

6-DATE OF BIRTH (month, day and year) Oct 15. 1864

7-AGE 59 yrs. 8 mos. 18 ds. | If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER John Dunham

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Margaret A. Dunham

(Address) 325 Wellington Lane

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 26-24

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to June 26, 1924

that I last saw him alive on June 26 1924

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Endocarditis

Pulmonary Edema (Duration) ... yrs. ... mos. 5 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Norbert G. Welsh M. D.

6/27, 1924 (Address) 2151 Wolfe ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Olivet Cemetery	June 30 1924
20-UNDERTAKER.	ADDRESS
F. B. Hopkins	2236 Eutaw ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 27 1924

MARGIN RESERVED FOR BINDING

FEB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88221 D 88221

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Caldwell

(a) RESIDENCE NO. St. Mary's Orphanage ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	10	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) md

PARENTS

10 NAME OF FATHER John Caldwell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Louisa Wilt 6/28/24

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) md.

14 Informant Hosp. Records
(Address)

15 Filed 19 Robert F. Harrison,
Registrar

Burial Permit Clerk.

JUN 28 1924

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1924, to June 27, 1924, that I last saw her alive on June 27, 1924, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, bronchial + laryngeal

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) acute myocarditis

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? at St. Mary's Orphanage

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Cultures (+)

(Signed) B MacGowan M. D.

(Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	June 28 1924
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1412 E Fayette St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88222

CERTIFICATE OF DEATH.

161-00 D 88222

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Argyle ave St., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Perrine

(a) RESIDENCE NO. 1200 Argyle ave St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1924

7 AGE Years 0 Months Days If LESS than 1 day 11 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Robert Perrine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lillian Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mother
(Address) .....

15 Filed ..... 19 ..... Registrar
Robert F. Harrison,
Burial Permit 1557 Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1924

17 I HEREBY CERTIFY, That I attended deceased from June 26, 19 24 to June 26, 19 24
that I last saw h'm alive on June 26, 19 24,
and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.
(30 wks fetus)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Johns Rees ..... M. D.

6/27/24 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health, ADDRESS .....

JOHNS HOPKINS HOSPITAL JUN 28 1924

W. M. WOODALL

Spec. 6-9-19—H. P. Co.—1000 Blks.

D 88223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 1817 Fornon ST.: 15 WARD)

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wyatt Frazier

(a) RESIDENCE. No. 1817 Fornon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 15, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Annie Frazier
(Address) 1817 Fornon St

15 Filed JUN 28 1924 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25/24

17 I HEREBY CERTIFY, That I attended deceased from 6/16/ 19 24, to 6/25 19 24

that I last saw him alive on 6/25/ 19 24

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. B. Staunton M. D.

6/26 19 24 (Address) 912 Gilmor St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 28 1924

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1725 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

88224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88224

129 D 88224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3830 Falls Road ST., (3 WARD)

2-FULL NAME William J. Mosenheimer

(a) RESIDENCE NO. 3830 Falls Road ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Emma E Mosenheimer

6 DATE OF BIRTH (month, day, and year) Mch 14 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER Peter Mosenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Susan Sterner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carrol Co Md

14 Informant Emma Mosenheimer

(Address) 3830 Falls Road

15 JUN 29 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 27th June 1924

17

I HEREBY CERTIFY, That I attended deceased from Nov 14th, 1923, to June 27th 24

that I last saw h. alive on June 27th 24

and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis. acute Diffuse Ep (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) J. F. D. Lucas M.D.

6/28, 1924 (Address) 1127 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hanover. Pa	June 29 1924

20 UNDERTAKER ..... ADDRESS

H S Marshall 3539 Falls Road

Spec.—1-10-21—M&T—1500 Blks.

Maud A. Elliott

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88225

CERTIFICATE OF DEATH.

X 144 D 88225

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maud A Elliott

(a) RESIDENCE No. 2001 Bardeen St., WARD

(Usual place of abode)

(If non-resident give city or town and State) New York.

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J Elliott

6 DATE OF BIRTH (month, day, and year) — 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Niagara Falls N.Y.

PARENTS

10 NAME OF FATHER Frank L. Feeney

11 BIRTHPLACE OF FATHER (city or town) Toronto (State or country) Canada

12 MAIDEN NAME OF MOTHER Josephine L. Lyons

13 BIRTHPLACE OF MOTHER (city or town) Rochester (State or country) N.Y.

14 Informant William J. Elliott

(Address) 2001 Bardeen St

15 Filed JUN 29 1924 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/1924

17

I HEREBY CERTIFY, That I attended deceased from 6/27/, 1924, to 6/27/, 1924,

that I last saw h alive on 6/27/24, 19....,

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Previa

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Obstruction

(Signed) Thomas F Feeney M. D.

, 19 (Address) 457 E. 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Niagara Falls N.Y.	June 28, 1924
20 UNDERTAKER E. A. Winfield Jr.	ADDRESS 501 E 22 St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 12-23-21—E.B.R.S.—400 Pds.

D 88226

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 88226

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3806 College ave St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bessie Soffs

(a) Residence No. 3806 College ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 17 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Hebrew

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Soffs

6-DATE OF BIRTH (month, day and year) 1866 May

7-AGE. 57 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... 03

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER. L. Yanoseritz

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Bessie Yanoseritz

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Russia

14-

(Informant) Daughter

(Address) 3806 College Ave

15-

Filed JUN 29 1924 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/28/24

17- I HEREBY CERTIFY, That I attended deceased from d/s r, 19 22, to June 28 19 24, that I last saw h alive on June 28 19 24, and that death occurred, on the date stated above, at 7 8 m. The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(Duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) — yrs. mos. ds.

18-Where was disease contracted if not at place of death? 1733 Lombard St. E

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. N. Sisco M. D

6/28. 1924 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Hebrew Washington Rd	6/29 1924
20-UNDERTAKER.	ADDRESS
Jack Levin	1439 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88227

CERTIFICATE OF DEATH.

9 D 88227 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 338 S. Mount ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Wharry

(a) RESIDENCE NO. 338 S Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Feb 27 1924.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Wm Wharry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Wegner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Wm. Wharry

(Address) 338 S. Mount St

15 Filed JUN 29 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1924

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1924, to June 28, 1924, that I last saw h/m alive on June 28, 1924, and that death occurred, on the date stated above, at 11-45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Pertussis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY [illegible]

(Secondary) Bronchopneumonia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo W Hemmeter, M. D.

6/28, 1924 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul's Cemetery Woodlawn — DATE OF BURIAL: 6/29 1924

20 UNDERTAKER: Geo Lembach & Son — ADDRESS: 647 W Pratt St

Rec—12-23-21—E.B.F.S.—400 Bks.

D 88228 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 88228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1000 E Pratt St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Klein

(a) Residence No. 1000 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John K. Klein

6-DATE OF BIRTH (month, day and year) Aug 14, 1837

7-AGE. 86 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) Not

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Adolph Martin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Dora Lutz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) John E Klein Son

(Address) 1000 E Pratt St

15-

Filed JUN 29 1924 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 26th 24

17- I HEREBY CERTIFY, That I attended deceased from 6-1 24, to 6-26 19 24

that I last saw h[illegible] alive on 6-26 19....

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Uthral Regurgitation

(Duration) 1 yr. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Pending

What test confirmed diagnosis?

(Signed) F Reginald [illegible] M D

6-27-1924 (Address) 1000 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Carmel

DATE OF BURIAL. June 1 1924

20-UNDERTAKER. John Allries

ADDRESS 1008 Aliceanna

1—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH may be properly classified. Exact statement in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 88229

1-PLACE OF DEATH

DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1803

1803 D 88229

CITY OF BALTIMORE: (No. Belair road near Oldham) 9 (WARD)

REGISTERED NO.

(If death occurred in hospital or institution, give NAME instead of street number and fill out No. 1)

2-FULL NAME Alexander Unverzagt

(a) RESIDENCE NO. 1734 Montpelier ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Walters

6 DATE OF BIRTH (month, day, and year) 1/18/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Unverzagt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Jeanette Cullon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Lillian Coulton (Address) 1734 Montpelier St

15 Filed ..... 192 ..... Robert P. Harrison, Registrar

JUN 2 9 1924

Burial Permit

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained [illegible] said Inquest (autopsy or inquiry) find that said deceased came to [illegible] on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Auto Accident

Accidental

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

(Signed) [illegible] M. D.
(Coroner.)

June 27, 1924 (Address) 102 E. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem DATE

20 UNDERTAKER

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-24—M&T—1500 Bks.

1909

D 88230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 D 88230

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. WARD 1)

2-FULL NAME Greenbury Sevier

3(a) RESIDENCE No. 2627 Fait Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Sevier

6 DATE OF BIRTH (month, day, and year): Jan 1878

7 AGE: Years 46 Months 6 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer Bleach

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Sevier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eliz Cearnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records (Address)

15 FILED JUN 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1924

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1924, to June 27, 1924, that I last saw him alive on June 27, 1924, and that death occurred, on the date stated above, at 4:05 a. m.

The CAUSE OF DEATH* was as follows:

Meningitis Cerebro Spinal

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Multiple Lung Abscess.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 2627 Fait Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical Exam't

(Signed) Robert Cunningham, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: June 30 1924

20 UNDERTAKER: A. Sander Sons ADDRESS: 1710 Fleet

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-901 D 88231

1-PLACE OF DEATH

City of BALTIMORE: (No. 734 W Franklin St., 17 Ward)

Registered No.

2-FULL NAME. Druesilla Howard

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 734 W Franklin St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). 070

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), "

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), "

14- (Informant) Mary Stanger (Address) 734 W Franklin

15- Filed JUN 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/26/24

17- I HEREBY CERTIFY, That I attended deceased from June 24 19 24 to June 26 19 24

that I last saw h. alive on June 25 19 24

and that death occurred, on the date stated above, at 12:05 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. McCard M. D.

6/26 1924 (Address) 2005 O'Dell Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Brook Cem. Govans Md DATE OF BURIAL 6/30- 19

20-UNDERTAKER. Daniel Easton ADDRESS 916 Eas

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88232

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 88232

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 833 N. Fulton Avenue St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie L. Evans

(a) Residence No. 833 N. Fulton Avenue St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Gilman P. Evans

6-DATE OF BIRTH (month, day and year) May 21, 1857

7-AGE. 67 yrs. 1 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Long Green
(State or Country) Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, Norval Wilson Guyton

11-BIRTHPLACE OF FATHER (city or town) Long Green
(State or Country) Balto. Co. Md.

12-MAIDEN NAME OF MOTHER, Catherine Luff

13-BIRTHPLACE OF MOTHER (city or town) Bucks Co.
(State or Country) Pa.

11- (Informant) Dr. Gilman P. Evans
(Address) 833 N. Fulton Avenue

15- Filed JUN 29 1924 Robert P. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 27/24

17- I HEREBY CERTIFY, That I attended deceased from Apr 1923 to June 27 1924 that I last saw her alive on June 27 1924 and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 6 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer A. Todd M. D.

6/28. 1924 (Address) 735 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Green Mount Cemetery	6/30 1924

20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D 88233

HEALTH DEPARTMENT—CITY OF BALTIMORE

1803 ✓

188 D 88233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marian K. Coolahan.

(a) RESIDENCE No 1805 Penrose Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos. 1 ds. How long in U. S., If of foreign birth? ---yrs.---mos.---ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) September 25th, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	9	1.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William P. Coolahan.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Marian Ziegler.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Marian Coolahan. (mother)
(Address) 1805 Penrose Ave.

15 Filed JUN 2 9 1924, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed about the body, fractured Pelvis. Accidentally struck, knocked down and run over by an automobile truck. (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Rennhardt, M. D. (Coroner.)

June 27, 1924 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Howard & Saratoga Sts. June 26, 1924

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	6/30/24
20 UNDERTAKER Sir W. Finley Fulton	ADDRESS Fayette

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-24—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88234

CERTIFICATE OF DEATH.

161-00 D 88234

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2142 Boyd ST., 20 WARD)

2-FULL NAME Grace Sparrow

(a) RESIDENCE No. 2142 Boyd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3/24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	0	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph R. Sparrow

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Graham

13 BIRTHPLACE OF MOTHER (city or town) Balto - Md
(State or country)

14 Informant Mary Sparrow
(Address) 2142 Boyd St.

15 Filed JUN 29 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th 1924

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. 0 mos. 25 ds.

(Signed) Thos B. Horton, M. D.
(Coroner.)

June 28. 1924 (Address) Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 6/30 1924

20 UNDERTAKER Geo A Imlay

ADDRESS Fulton & Fayette

JUN 29 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-28—M&T—100 Blks.

D 88235

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 74 D 88235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Josephs Monastery 320 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Father Guido Teresi

(a) RESIDENCE No. St Josephs Monastery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 45	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Priest 018
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Father Fabiani
(Address) St Josephs Monastery

15 JUN 29 1924, 192 Registrar Robert P. Harrison

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained I find that said deceased came to ... death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) about ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

(Signed) Thos. B. Norton, M. D.
(Coroner.)

June 28th, 1924 (Address) Curtis Bay Balto Md

*State the Disease Causing Death, or if Deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for directions.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hoboken N. J.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/1 1924
20 UNDERTAKER George A Farley	ADDRESS Fulton & Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D 88236

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 W. Lee St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Eunice Reamy

(a) Residence No. 7 W. Lee St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Dec 24 1923

7-AGE. .....yrs. 6 mos. 1 ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Elwin J. Reamy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Eunice Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant): Elwin Reamy

(Address): 7 W. Lee St.

15- Filed JUN 29 1924 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 28/24

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1924 to June 28 1924

that I last saw her alive on June 20 1924

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry L. Wilson, M. D.

, 19 (Address) 13 N. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pilgrim's Island Cemetery DATE OF BURIAL, June 30 1924

20-UNDERTAKER: A. Howard Evans ADDRESS 386 Fort Ave

Spec—12-23-21—E.P.R.S.—400 lbs.

D 88237

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 88237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 22 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Cox

(a) Residence No. 618 Warren St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 6/18/94

7-AGE, 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Arthur Cox

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Louise

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland.

14-

(Informant)

(Address) City Home Hospital

15-

Filed JUN 30 1924 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/28/24

17- I HEREBY CERTIFY, That I attended deceased from June 11 1924 to June 28 1924

that I last saw him alive on June 28 1924

and that death occurred, on the date stated above, at 4-45 A.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma -

(Pyloric obstructum)

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

*Did an operation precede death? Yes Date of June 21, 1924

Was there an autopsy? Dr.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. F. Sullivan, M. D.

, 19 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	7/1/24
20-UNDERTAKER.	ADDRESS 916
Dent Earlood	Penn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-50—MAT—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88238

44 D 88238

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Pearce ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Rollins

(a) RESIDENCE No. 1629 Pearce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col'd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Rollins

6 DATE OF BIRTH (month, day, and year) Aug 14 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

040

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Perry Rollins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Sarah Rollins
(Address) 1629 Pearce St

15 JUN 3 0 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 192 4

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

10 minutes (duration)

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

040

(Signed) Thos. B. Horton, M. D.
(Coroner.)

June 28, 1924 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL 7/1/24

20 UNDERTAKER Dent Eastes

ADDRESS 916 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 88239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88239

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 455 St. Mary's St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Johanna Brown

(Residence in Baltimore: No. 455 St Marys St St.; 50 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Ireland

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

6-DATE OF BIRTH, June 17, 1845
(Month) (Day) (Year)

7-AGE, 79 yrs. mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Dont know

11-BIRTHPLACE OF FATHER (State or Country). Dont know

12-MAIDEN NAME OF MOTHER. Dont know

13-BIRTHPLACE OF MOTHER (State or Country). Dont know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Roal

(Address) 455 St Marys St

15-

Filed ..... 192.....

ROBERT N. KRAUTER, Burial Permit Clerk. Registrar.

JUN 30 1924

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Heuisler M. D.
(Coroner.)

June 26 1924 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem — DATE OF BURIAL. 6/30 1924

20-UNDERTAKER. Daniel Easton — ADDRESS 916 Park ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH PENCIL OR INDELIBLE INK.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-007

D 88240

CERTIFICATE OF DEATH.

REGISTERED NO. D 88240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Druid Hill Av ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H Payne

(a) RESIDENCE. NO. 1307 Druid Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olivia B Payne

6 DATE OF BIRTH (month, day, and year) Feb 25 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Messenger Jdy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U S Gov.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Sly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Olivia B Payne

(Address) 1307 Druid Hill Ave

15 JUN 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

17

I HEREBY CERTIFY, That I attended deceased from May 27 1924 to June 27 1924

that I last saw him alive on June 27 1924

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

2 mos. —

CONTRIBUTORY (Secondary) ✓ (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S B Hughes, M. D.

June 28 1924 (Address) 1413 S Druid Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn.	July 1 1924

20 UNDERTAKER Franklin W Seitz ADDRESS 709 W 33rd St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1000 M - M&T - 1500 Blks.

112546

D 88241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 88241

1-PLACE OF DEATH John's Hop. Hospital

CITY OF BALTIMORE: (No. ~~570 Fork Rd~~ ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christopher Newcomer

(a) RESIDENCE NO. 1314 Lexington ST., St. WARD 5

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Newcomer

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 83 | Months ? | Days ? | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Newcomer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: McElroy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Friends

(Address) Johns Hopkins Hosp.

15 Filed: [illegible] 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1924

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1924, to June 29, 1924,

that I last saw him alive on June 29, 1924

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Arteriosclerosis

Hypertension

Insufficiency (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Cerebral hemmorhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T. R. Harmon, M. D.

6/29, 1924 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gt Falls Cemetery — DATE OF BURIAL: July 1 1924

20 UNDERTAKER: W. M. Rouken — ADDRESS: 2238 N Monte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88242

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D 88242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1600 Pa ave St., 14 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Wirth

(a) Residence No. 1600 Pa ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret J. B. Wirth

6-DATE OF BIRTH (month, day and year) Nov 29 56

7-AGE. 67 yrs. 6 mos. 28 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer) Sugar 045

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Wirth

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Weber

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs Margaret J. B. Wirth

(Address) 1600 Pa ave

15- Filed JUN 3 0 1924 ROBERT R. KRAUER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 27 24

17- I HEREBY CERTIFY, That I attended deceased from May 25, 1924, to June 27, 1924, that I last saw h[illegible] alive on June 26, 1924 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J E Daugherty M. D.

, 19 (Address) 1602 Pa ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, June 30 1924

20-UNDERTAKER, W M Routson — ADDRESS 2208 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D 88243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88243

CERTIFICATE OF DEATH.

170

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 So. Payson ST. 21 WARD)

2-FULL NAME Nellie Ripke

(a) RESIDENCE NO. 27 So. Payson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank C Ripke

6 DATE OF BIRTH (month, day, and year) Feb 9th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER John Belcher ~~Unknown~~

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Frank C. Ripke
(Address) 27 So. Payson St.

15 Filed ..... 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Suicide-Shot Self through Heart

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

June 28th, 1924 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL June 30 1924

20 UNDERTAKER W M Routson

ADDRESS 2238 N. Booth

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88244

D 88244

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp X. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. D. Raw

(a) RESIDENCE NO. 2130 Walbrook Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Raw

6 DATE OF BIRTH (month, day, and year) Apr. 2. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Home Friendly

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. D. Raw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George D. Raw Jr

(Address) 2130 Walbrook ave

15 Filed . 19 ROBERT R. KRAUTER, Registrar

JUN 30 1924 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6. 27. 24

17 I HEREBY CERTIFY, That I attended deceased from 5. 28. 24 to 6. 27. 24

that I last saw h alive on 6. 27. 24 19

and that death occurred on the date stated above, at 8 45 a m.

The CAUSE OF DEATH* was as follows:

Streptococcal gonitis.

?

(duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. 24 hrs

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-26-24

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo A Tompkins M. D.

, 19 (Address) Md Gen. Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 30 1924
20 UNDERTAKER Mr & Mrs John M. Teufel & Son	ADDRESS 801 N. Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88245

CERTIFICATE OF DEATH.

57 D 88245

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Hardesty

(a) RESIDENCE NO. 1555 Friendship ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Donald Hardesty

6 DATE OF BIRTH (month, day, and year) Nov 22, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	43	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry Noah Sunmerdorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Donald Hardesty (Address) 1555 Friendship St

15 JUN 3 0 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1924, to June 29, 1924.

that I last saw h[illegible] alive on June 28, 1924,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about 10 yrs. — mos. — ds.

(duration)

CONTRIBUTORY (Secondary) diabetic coma

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Chemical

(Signed) Edward Dorsey, M. D.

, 19 (Address) 76 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland — DATE OF BURIAL June 1924

20 UNDERTAKER Wm Cook — ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVE BANK NOTE CO.

Spec.—1-19-21-M&T—1500 Bks.

D 88246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 88246

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander H. Maley or Frank O'Mallagher

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed JUN 3 0 1924 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26 1924

17 I HEREBY CERTIFY, That I attended deceased from 8-14 1922 to 6-26 1924

that I last saw him alive on 6-25 1924

and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

Syphilis; Arteriosclerosis; Emphysema; Chronic Bronchitis; Chronic myocarditis; Myocardial degeneration (duration) 3 yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude J. Grace, M. D.

6-27 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 6/30 1924

ADDRESS 502 E 1st St

20 UNDERTAKER Wm Cook

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88247

161-001 D 88247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital (St. Paul and Franklin)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Lewis

(a) RESIDENCE No. 5217 York Road WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 28, 1924

7 AGE: Years — Months — Days — If LESS than 1 day hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Bernard McFadden Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nellie Elizabeth Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Father (Bernard McFadden Lewis)

(Address) 5217 York Road

15 Filed JUN 3 0 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 28 11 AM, 1924, to June 28 5 PM 1924.

that I last saw her alive on June 28, 5 PM, 1924,

and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity, 9 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings.

(Signed) B. McKhodes M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hayford Rd DATE OF BURIAL 6/30 19[illegible]

20 UNDERTAKER William Cook ADDRESS 501 E Hoff

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No 1413 Reedsdale St. St., 16 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anne M. Schofield

(a) Residence No. 1413 Reedsdale St. St., ... Ward..... Balto Co. Md
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Orlando B. Schofield

6-DATE OF BIRTH (month, day and year) Oct 28 1847

7-AGE, ... 76 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work..... Artist
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Kent Co Md

PARENTS.

10-NAME OF FATHER Wm A Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kent Co Md

12-MAIDEN NAME OF MOTHER Catherine Stiffs

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Caroline Co

11- (Informant) Mrs. Mary Bryne

(Address) 1413 Reedsdale St

15- Filed JUN 30 1924 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 28/24

17- I HEREBY CERTIFY, That I attended deceased from June 26, 19 24 to June 28, 19 24

that I last saw h.. Alive on June 26, 19 24

and that death occurred, on the date stated above, at 6 40 P.M.

The CAUSE OF DEATH* was as follows:

Toxaemia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Left side Hemiplegia

(Duration) ..... yrs. ..... mos. 3 ds.

18-Where was disease contracted if not at place of death? Over

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dawood Kahn M. D.

6/29, 19 24 (Address) 1027 Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL, June 30, 19 24

20-UNDERTAKER. Williamson & Son

ADDRESS E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 88249

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88249

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2-W-25th St., 12 Ward) Registered No.....

2-FULL NAME Margaret Ford Smith

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 2 W-25 St. St., 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 0 mos. 22 ds. How long in U. S., if of foreign birth? 57 yrs. 0 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of None

6-DATE OF BIRTH (month, day and year) June-5-1867

7-AGE, 57 yrs. 0 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Asst Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) Fer Trane Co.

(c) Name of employer (above)

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas. T. Smith

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Hester Krebs

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Mrs. Mary K. Owens Sister

(Address) 2-W-25th St. City.

15- Filed JUN 3 1924, 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 27. 1924

17- I HEREBY CERTIFY, That I attended deceased from June 10th, 19 24, to June 27, 19 24, that I last saw h.. alive on June 26, 19 24, and that death occurred, on the date stated above, at 9.05 a.m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. One ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Stelwagon F. Stellman M. D.

, 19 (Address) 6 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, June 30 19 24.

20-UNDERTAKER STEWART & WOODEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Clements)

D 88250

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D 88250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital 6 ST., WARD)

2-FULL NAME Mrs. Viola C Clements

(a) RESIDENCE NO. 18 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Clements

6 DATE OF BIRTH (month, day, and year) Jan 31 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Oldfather

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Minnie Cramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records.

(Address)

15 Filed JUN 30 1924 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28/24

17

I HEREBY CERTIFY, That I attended deceased from 6/20/24, 19..., to 6/28/24 19...,

that I last saw h alive on 6/26/24 19...,

and that death occurred, on the date stated above, at 5.00 m.

The CAUSE OF DEATH* was as follows:

(Infected) Miscarriage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) ? yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) K. W. Buckley M. D.

(Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	July 1 1924
20 UNDERTAKER	ADDRESS
Peter Nicolaus & Co	Eastern Ave

Original Primary Certificate Retained by Registrar

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88251

CERTIFICATE OF DEATH.

44 D 88251

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 328 S. Collington Ave St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatius . Popiolek

(a) Residence No. 328 S. Collinton Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frances. Popiolek

6-DATE OF BIRTH (month, day and year) Jan. 10 1870

7-AGE. 54 yrs. 5 mos. 18 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer) By Trade

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Poland

PARENTS.

10-NAME OF FATHER, William. Popiolek

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Mrs. Frances. Popiolek

(Address) 328 S. Collinton Ave

15- Filed JUN 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 28 1924

17- I HEREBY CERTIFY, That I attended deceased from June 20 19 24 to June 28 19 24

that I last saw h[illegible] alive on June 28 19 24

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Cystric Carcinoma

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm J Rosewell M. D

(Address) 180 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Rosary	July 1 19 24
20-UNDERTAKER	ADDRESS
John F. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-24—CHAT—1500 Blks.

173 229

D 88252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88252

CERTIFICATE OF DEATH.

x90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Temple

(a) RESIDENCE NO. 1328 Mut Ave. Sparrows Pt. Md. (7 days) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha P Temple

6 DATE OF BIRTH (month, day, and year) Feb 2. 1866

7 AGE Years 57 Months ? Days ? If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Policeman

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Temple

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Regards

(Address) John Hopkins Hosp.

15 JUN 30 1924 ROBERT H. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1924

17 I HEREBY CERTIFY, That I attended deceased from May 26 1924 to June 28. 1924.

that I last saw him alive on June 28, 1924,

and that death occurred, on the date stated above, at 12 40 p.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease

Aortic Stenosis & Insufficiency

Mitral Insufficiency & Stenosis

Myocardial Insufficiency (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) John A Kolmer (Kolmer) M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL JUNE 30 1924

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D 88253 HEALTH DEPARTMENT—CITY OF BALTIMORE D 88253

1884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. University Hospital St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs P. Hogan

(a) RESIDENCE No. 1202 W Cross St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 4-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21	9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Md. Trust Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Hogan.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Margt. Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Wm. Hogan.
(Address) 1202 W. Cross St

15 JUN 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or~~ inquiry.)
thereon and from the evidence obtained by said ~~(inquest, au-~~
~~topsy or inquiry.)~~ find that said deceased came to his death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Struck by Electric Light Pole

(duration) yrs. mos. ds.

(Signed) H K Gorsuch, M. D.
(Coroner.)

6-30 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 7/1/24

20 UNDERTAKER Fred A. Kramer & Son ADDRESS 703 Hanover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

NB.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 38254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 38254

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 913 McDonough St.; WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Anderson

(Residence in Baltimore: No. 913 McDonough

S[illegible] yrs., 4 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) S

6-DATE OF BIRTH, January 20, 1924
(Month) (Day) (Year)

7-AGE, 5 yrs. 8 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), North Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), [illegible]

12-MAIDEN NAME OF MOTHER Virginia Anderson

13-BIRTHPLACE OF MOTHER (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Carl Elliott

(Address) 1725 Ashland Ave

15-

Received JUN 3 0 1924, ROBERT R. KRAUTER,
Burial Permit [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1924
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Generalized Tuberculosis

(Hodgkins Disease as Stephens

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Fuller M. D.
(Coroner)

6-28-1924 (Address) 706 E Nort[illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Raleigh N. C. DATE OF BURIAL, June 29, 1924

20-UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Ashland Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D 88255

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D 88255

Registered No.....

City of BALTIMORE: (No. 45 S Schroeder St., 18 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Burke

(a) Residence No. 45 S Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Michael Burke

6-DATE OF BIRTH (month, day and year) Unknown 86

7-AGE, 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER John Donohue

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Bridget Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland.

14- (Informant) Mrs. Nicholas Burke

(Address) 45 S Schroeder St.

15- Filed JUN 30 1924 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 28-1924

17- I HEREBY CERTIFY, That I attended deceased from June 24, 1924, to June 28, 1924, that I last saw her alive on June 28, 1924, and that death occurred, on the date stated above, at 8-25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Causing Right Hemiplegia and Aphasia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

(Duration) 6 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry G. Pate M. D.

June 29 1924 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, July 2 1924

20-UNDERTAKER, John H Power & Son ADDRESS 90 Holbus St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Griesacker

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88256

CERTIFICATE OF DEATH.

90 D 88256

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1056 W Barre st ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Griesacker

(a) RESIDENCE NO 1056 W Barre st ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Griesacker

6 DATE OF BIRTH (month, day, and year) January 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Schaub

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Emhardt

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant John A. Griesacker (Address) 1056 W Barre St

15 Filed JUN 3 01924 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Don't know yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Samuel (Coroner.) M. D.

1-30 , 1924 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Feb 1 1924

20 UNDERTAKER Geo J Crau & Son ADDRESS 901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D 88257

D 88257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 W. Lexington ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Abraham Belsinger

(a) RESIDENCE NO. 2221 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Multigraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Consolidated Gas Electric Light & Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Simpson Belsinger

11 BIRTHPLACE OF FATHER (city or town) Savannah
(State or country) Ga.

12 MAIDEN NAME OF MOTHER Mary C. Amerebach

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Harry S. Belsinger
(Address) 2221 W. Lexington St.

15 Filed JUN 30 1924 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29— 1924.

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1924, to June 29, 1924.

that I last saw him alive on June 29— , 1924.

and that death occurred, on the date stated above, at 6:35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary) Pneumococcic Meningitis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Roland, M. D.

6-29. 1924 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/1 1924

20 UNDERTAKER Henry C. Bramm & Son

ADDRESS 517 N. Schroeder St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-24 M&T—1500 Bks.

88258

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002 ✓ D 88258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Perry

(a) RESIDENCE NO. 23 State Circle - Annapolis Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20, 1924

7 AGE: Years | Months | Days: 4 | If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ood

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Richard Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Estelle Donovan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital.

15 Filed JUN 30 1924 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1924

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1924 to June 24 1924.

that I last saw him alive on June 24 1924.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Intra-cranial haemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) W. W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 30, 24

20 UNDERTAKER: William G. Schaeffer — ADDRESS: 816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

1733 ✓ HEALTH DEPARTMENT—CITY OF BALTIMORE 65-002 ✓

1733 D 88259 CERTIFICATE OF DEATH. + 65 D 88259

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney A. Cook

(a) RESIDENCE NO. 985 Market Place ST. WARD California

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) June 26, 1881

7 AGE: Years 43 Months 0 Days 4 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cal.

PARENTS

10 NAME OF FATHER William Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Whitfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Friends (Address)

15 JUN 30 1924 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17

I HEREBY CERTIFY, That I attended deceased from Mar. 11, 1924, to June 30, 1924, that I last saw him alive on June 30, 1924, and that death occurred, on the date stated above, at 4.05 A m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Gland section

(Signed) Trevor Owen M. D.

Jun 30 1924 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL June 30 1924

20 UNDERTAKER Geo. A. Tuttle ADDRESS 2700 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88260

CERTIFICATE OF DEATH.

60 D 88260

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 120 N Curley st ST.; 6 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Newborn of John and Rose Offidani

(Residence in Baltimore: No. 120 N Curley st St.; .....yrs., ...mos. .....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. fem

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, June 29, 1924 (Month) (Day) (Year)

7-AGE, ...yrs. .....mos. .....da.

If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, John Offidani

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Rose Cilenza

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ....., 191... Robert F. Harrison, Registrar.

JUN 30 1924

Burial Permit Clerk

1564

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 29, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191.....,
that I saw h[illegible] alive on .....191.....,
and that death occurred, on the date stated above, at 5:35 a.m.
The CAUSE OF DEATH* was as follows:

.....Congenital debility.....
.....
..... (Duration).....yrs.....mos.....da.

CONTRIBUTORY (Secondary).....
..... (Duration).....yrs.....mos.....da.

(Signed).....Chas. Testa M. D.
....., 191... (Address).....210 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....da. In the State .....yrs. .....mos. .....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Dr Rohrer State Board.	....., 191...
20-UNDERTAKER	ADDRESS.

JUN 30 1924

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

172 B 8826 F

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8826 F

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Hammett

(a) RESIDENCE NO. Bristol Tenn ST., ... WARD Bristol Tenn.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 13 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Tenn

PARENTS

10 NAME OF FATHER Dr J. P. Hammett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tenn

12 MAIDEN NAME OF MOTHER Margt A James

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tenn

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 UN 3 0 1924 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1924

17 I HEREBY CERTIFY, That I attended deceased from June 17 - 1924. to June 30. 1924.

that I last saw ~~he~~ alive on June 30. 1924.

and that death occurred, on the date stated above, at 10 15 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia (2 days)

+ Uremia due to pyelonephritis

+ chronic nephritis

(duration) + ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) carcinoma stomach with advanced metastasis

(duration) + ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Charles F. Bridgford, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bristol Tenn

DATE OF BURIAL: June 30 1924

20 UNDERTAKER: Chas F. Trawick Son

ADDRESS: 116 Mt Royal Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D 88262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 D 88262

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 902 Madison Ave St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Jacob H. Billmyer

(a) Residence No. 902 Madison Ave St., ... Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Camilla Billmyer

6-DATE OF BIRTH (month, day and year) 6-24-1858

7-AGE. 65 yrs. 8 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Wall Paper

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Daniel Billmyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Emily Stickstall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

11- (Informant) Camilla Billmyer

(Address) 902 Madison Ave

15- Robert P. Harrison,

Registrar.

JUN 30 1924

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 28/24

17- I HEREBY CERTIFY, That I attended deceased from April 11 19 24 to June 28 19 24

that I last saw h. alive on June 27 19 24

and that death occurred, on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy —

Paralysis right side

(Duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. H. Burbage M. D

19 (Address) 1104 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvert — DATE OF BURIAL, June 1 1924

20-UNDERTAKER Fuchs & Lindenberger ADDRESS North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88263 45 D 88263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. ..... ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Emma V. Watson

(Residence in Baltimore: No. 1400 W. Lanvale St.; 66 yrs., 5 mos. 20 ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan (Month) 10 (Day), 1864 (Year)

7-AGE, 60 yrs. 5 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Levi Reed Dyer

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER Juliann Sloop

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Watson

(Address) 1400 W. Lanvale St

15-

Filed JUN 3 0 1924 Robert P. Harrison..... Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 30 (Day), 1924 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1924, to June 30 1924, that I saw h[illegible] alive on June 30 1924, and that death occurred, on the date stated above, at 5.25 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

General Carcinomatosis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) [illegible] M. D.

....., 192... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? at Home

Former or usual residence Same as noted above

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery — DATE OF BURIAL, July 2 1924

20-UNDERTAKER Wm J. Tackney Sons — ADDRESS North Ave

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88264

CERTIFICATE OF DEATH.

D 88264

1-PLACE OF DEATH Maryland Genl. Hospital REGISTERED NO. C

CITY OF BALTIMORE: (No. Lee ST.; 14 RD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Mildred Petticord

(Residence in Baltimore: No. 1433 Madison Ave. St. 20 yrs., mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, December 15, 1884 (Month) (Day) (Year)

7-AGE, 40 yrs. 6 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Co., Md.

PARENTS.

10-NAME OF FATHER, Wm. H. Petticord

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Elizabeth Lentz

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Petticord

(Address) 1433 Madison Ave

15-

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JUN 30 1924

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1924 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1924, to June 28 1924, that I saw her alive on June 28 1924, and that death occurred, on the date stated above, at 5.10 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) yrs. mos. 3 ds.

(Signed) Wm A Brumdlitt M. D.

, 191... (Address) Md Gen Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 8 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Same as noted above

19-PLACE OF BURIAL OR REMOVAL. Lorraine Cem. DATE OF BURIAL, July 1, 1924

20-UNDERTAKER Wm. J. Tallmadge Son ADDRESS North Ave

Has no present issue - Next of kin Angela.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88265

D 88265

162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] St., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Elliott

(a) RESIDENCE NO. 2001 Barclay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-27-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

800

9 BIRTHPLACE (city or town) (State or country): Boca City

PARENTS

10 NAME OF FATHER: Wm J Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Maud A Tierney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Canada

14 Informant: William J. Elliott
(Address) 2001 Barclay

15 Filed JUN 30 1924 19 Robert P. Harrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/ 19 24

17

I HEREBY CERTIFY, That I attended deceased from June 27, 19 24, to June 30, 19 24,

that I last saw h[illegible] alive on June 30, 19 24,

and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J Kelly M. D.

, 19 (Address) 457 E 22nd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Niagara Falls N Y

DATE OF BURIAL: June 30 19 24

UNDERTAKER: E A Weagley Jr

ADDRESS: 501 E 22 St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement in answer to each question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D 88266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 88266

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Valley St ST., 9 WARD)

2-FULL NAME Thomas Ridgely Haile

(a) RESIDENCE NO. 1308 Valley ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 9, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas J. Haile

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Mooney

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Thomas J. Haile
(Address) 1308 Valley St

15 JUN 3 0 1924

Robert P. Harrison.
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1924

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1923, to June 29, 1924.
that I last saw him alive on June 29, 1924
and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerative or infective Endocarditis

(duration) yrs. 7 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Austin F. Robinson M. D.

6/30 1924 (Address) 1307 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross M. G. Co	July 2 '24
20 UNDERTAKER	ADDRESS
Margaret F. Flynn	1417 Eutaw St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88267

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88267

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 76 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Hutton

(a) RESIDENCE No. Bay View Asylum St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Hutton,

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER ?.

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 JUN 30 1924 Robert P. Harrison, .19.....
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30 1924

17

I HEREBY CERTIFY, That I attended deceased from 12-21, 1923 to 6-30, 1924.

that I last saw him alive on 6-29, 1924,

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Senile Detinition

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sub.

(Signed) Claude A. Abrams, M. D.

6-30 1924 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park, Cty	July 2 1924
20 UNDERTAKER	**ADDRESS**
Margaret J. Hagan	1422 Light

Cor.—1-12-23—M&T—100 Bks.

D 88268

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88268

CERTIFICATE OF DEATH. 74

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen'l Hosp. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marvin H. Murray,

(a) RESIDENCE NO. 1700 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie L. Mitchell

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	8	20.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Contractor & Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Builders of Homes.
(c) Name of employer Murray & Haynes.

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER Wm. H. Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Rouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie L. Murray.
(Address) 1700 Edmondson Ave.

15 Filed JUN 30 1924 Robert P. Harrison, Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1924.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) arteriosclerosis 4 yrs.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Kennedy, M. D.
(Coroner.)

(Address) 2802 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL July 1924

20 UNDERTAKER Harry W. Ehlen ADDRESS 1946 W. North

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 88269

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 88269

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1125 Woodyear St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Thomas

(a) RESIDENCE NO. 1125 Woodyear ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Fountian Thomas.

6 DATE OF BIRTH (month, day, and year) March 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Anne Arundall Co Md.

PARENTS

10 NAME OF FATHER Chas. Peters

11 BIRTHPLACE OF FATHER (city or town) A. A. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Colbert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Helen Neal (Address) 1125 Woodyear St

15 Filed JUN 3 01924 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29—1924

17 I HEREBY CERTIFY, That I attended deceased from April 1— 1924 to June 29— 1924

that I last saw her alive on June 28— 1924

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonitis (Rheumatic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Labrippe (Jan-1924)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

, 19 (Address) 1239 Mt. Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemtery	July 1 1924
20 UNDERTAKER Mrs Jas. H. Dennis Rep T. E. Nelson	ADDRESS 1303 Pressman ST

Spec—12-23-21—E.B.R.S.—400 Eks.

D 88270 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 74-001

CERTIFICATE OF DEATH.

D 88270

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 804 Leaden Hall St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hester Fisher

(a) Residence No. 804 Leaden Hall St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Carey Fisher

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Benjamin Dixon

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER, Anne Giles

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14-(Informant) Lilly Smith

(Address) 726 Cathedral

15-Filed JUL 1 1924 ROBERT R. KRAUTER, Registrar.

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 29-1924

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1924 to June 29, 1924

that I last saw h. alive on June 29, 1924

and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy 4

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 2 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

6/30, 1924 (Address) 2005 Druid Hill Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn

DATE OF BURIAL. 7-2, 1924

20-UNDERTAKER. J. Wm H. Toadvine

ADDRESS 142 N Stricker St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.